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SYMPOSIUM ON THE MEDICAL, LEGAL AND SOCIAL ASPECTS OF THE ADOPTION LAW OF THE STATE OF MARYLAND UNDER CHAPTER 63 OF THE ACTS OF 1950[1]

INTRODUCTION

HONORABLE HERMAN MOSER, *Moderator*[2]

Ladies and gentlemen, we are here this evening, as I understand it, for the purpose of hearing a discussion and an explanation of one of the new and apparently little-understood Acts that affect the medical profession, the legal profession, those who are concerned with social service work here in the community, and, of course, the general public.

It is an Act that came into being in 1950. And it changed fundamentally and to a very great degree the adoption laws of the State of Maryland.

I have heard it said that it was passed with too little knowledge of the full implication of the law. On the other hand, I have heard it said that this subject has been debated for many, many years, and the evils which were thought to be corrected by the law were well understood by those who would be affected by its passage.

In any event, after we leave here this evening, I hope there will have been accomplished several things:

One. A better understanding of the law and its implications, and

Two. A better understanding of those evils which the law was thought to correct.

Perhaps it may lead to not only a better understanding of the law as it is, and if need be, a better law, but in any event I am sure after this group of experts in their fields are through discussing it, and then I hope with each other, we all will at least know more about it.

The first speaker is Dr. Georgeanna Seegar Jones. Dr. Jones received her degree from Johns Hopkins Medical School some years ago.

She is in the Department of Surgery at the Johns Hopkins, and has been in the Department of Gynecology as the Director of Research in Reproductive Physiology in the Department of Gynecology. Her present title at Johns Hopkins is Assistant Professor of Gynecology.

In addition to her academic position, she is a part-time private practitioner, who is largely devoted to the study of infertility.

I am perfectly sure she is going to have some interesting thoughts about the relationship between the subject with which she is thoroughly familiar and the subject which started out as an adoption law of the State of Maryland.

The next discussant is Thomas J. S. Waxter.

He is a graduate from Princeton. He is a graduate from Yale Law School. He was Chief Magistrate of the Juvenile Court of Baltimore from 1929 to 1936. He has been Director of the Department of Public Welfare since January of 1935, and, of course, that is the position that

[1] Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee.

[2] Judge of the Supreme Bench of Baltimore City.

most of us are most familiar with. He helped to organize and was a member of the Board of the Baltimore Emergency Relief Association.

He was a member of the group which organized the Legal Aid Bureau, and was Chairman of this Board for a great number of years.

He is President of the Maryland State Conference of Social Welfare.

He is a member of the Board of the Family and Children's Society.

He is a member of the City Jail Board and Committee for the Construction of a new Jail, which I think has become at least a drawing board reality.

He is a member of the Board of Directors of the Council of Social Agencies, and he is a member of the Board of Citizens Planning and Housing Association, as well as being a member of the Baltimore Youth Commission.

He was Chairman of the Sub-Committee on Medical Care—American Public Welfare Association.

He is Secretary of the Baltimore City Commission on Human Relations, and Administrator of Area Projects in Baltimore.

He is Director of the Emergency Welfare Services—in Civil Defense.

He also was one of the successful growers of nasturtia and radishes in Public School No. 61. (Laughter) And I can vouch for that, because we were in it together. (Laughter)

And then there is Andy Anderson—G. C. A. Anderson—who is a member of the Baltimore Bar. I almost did not know who he was until about ten minutes ago, when Mr. Waters brought me his history. I would have been at a complete loss if that had not been furnished. (Laughter)

He graduated from Mercersburg, spent one year at Princeton, and then went into the army.

He graduated from Princeton in 1921, and graduated from the Harvard Law School in 1924.

He was Secretary of the Baltimore City Bar Association, and later was President of the Baltimore City Bar Association, and was Vice President of the Maryland State Bar Association.

He was in charge of fuel oil rationing during World War II.

Incidentally, he has many other qualifications, and both as a member of the Bar and as a member of the Bench, I have known Mr. Anderson as being one who is always ever ready and willing to lend his considerable talents to any worthwhile cause. He has been used for good purposes many, many times by the Bench and the Bar in matters which the Bench and the Bar felt he could lead in order to bring about better situations.

I am perfectly sure that we all are going to leave, after hearing these three extremely well-qualified experts discuss these problems, much better informed. I know I shall.

We are going to do it in this way. I was given the rules by the Committee that is in charge of this meeting. The discussants have fifteen minutes each to develop their particular viewpoint on this question. There will then be certain questions, more or less pointed, asked by the Moderator. There are, I see, pads distributed here in the hall, and I assume there are pencils or pens available. There will be an open period of questions, but I am suggesting that before that period the questions be written down, and during the time that the Moderator is asking certain questions, those who have questions to ask will have an opportunity to pass them up, so that then we will have time to go over them, and they will be asked of the person whom the Moderator believes is best qualified to give the answers to them.

Now, the first person we are to hear from is Dr. Jones, who will have something to say about the medical aspects of the adoption law of the State of Maryland, Chapter 63 of the Acts of 1950.

Dr. Jones.

MEDICAL ASPECTS

GEORGEANNA SEEGAR JONES, M.D.[1]

Thank you, Judge Moser, especially for the introduction.

I was in Akron last week, and they were not so gentlemanly. They not only told my obstetrical history, but my age as well.

[1] Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine, and Gynecologist at The Johns Hopkins Hospital.

The medical problems involved in adoption are complicated by the fact that four individuals may be involved: the prospective mother, the baby, and the respective foster parents—a man and a woman. Thus, from a medical point of view, we may have involved an obstetrician, a pediatrician, a gynecologist and a urologist.

I am only a gynecologist, so perhaps some

questions that may arise I will have to call on my colleagues to answer.

For a logical presentation we will discuss first, the problems of the mother, then the baby, and finally those of the prospective adoptive parents.

Let us assume for illustrative purposes that the prospective mother is young, unmarried, and experiencing her first pregnancy. With this situation, the obstetrician is immediately aware that the situation demands care and attention, for in addition to the known hazards of a first pregnancy there are superimposed the emotional and psychological factors created by the situation in which the woman finds herself.

I say in addition to the hazards of a first pregnancy advisedly, because it is a statistical fact that the first pregnancy carries far more hazards than the subsequent pregnancies, until a parity of seven is reached.

What are the emotional aspects in this situation?

First not only her concern for her own physical well-being, which is real, and often important in any first pregnancy, but also concern for her financial assistance, which she must frequently care for herself. Second concern for the social stigmata which she brings upon herself and her family, and third concern for the welfare of her baby. All of these factors make for great emotional distress.

The careful conscientious obstetrician realizes he is facing a potentially difficult problem, as one of the most important complications of a first pregnancy is toxemia, followed by eclampsia. This condition is characterized, among other things, by an increased blood pressure, and many medical authorities believe that emotional factors play a part in hypertensive diseases and related disturbances. Thus the emotional make-up of the pregnant parent may be important.

Eclampsia may cost the life of the mother; if she survives, it may cause permanent disability and blindness in later life. Therefore from the standpoint of the mother, the medical care of the pregnancy is extremely important in order that the woman may be restored to society as a useful individual.

In addition to the medical problems of the mother that may arise during pregnancy, there are also potential complications for the baby. Probably the most controversial problem about the baby concerns the age at which it should be adopted. Everyone agrees that an adopted baby should be sound in mind and body, but there is a wide difference of opinion as to when this evaluation can be made. One of our most prominent authorities believes that such an evaluation can not be made until the child is one year old. Other equally capable authorities believe that if the pregnancy history and the type of delivery is known a capable pediatrician, observing a baby for as short an interval as three weeks, can make a fair estimate of its intellectual and physical capabilities. These are the two extreme views. The truth probably lies somewhere in between.

One must also be guided, of course, by practical aspects. It is frequently financially impractical to maintain a baby in a foster home for a period of as long as one year. Also, many pediatricians believe, from the baby's standpoint, that this may not be wise.

What are the pediatrician's major concerns for a baby that is to be considered for adoption? I am told that these are congenital abnormalities, and cerebral palsies, or related conditions. The congenital abnormalities, which include cardiac and gastro-intestinal abnormalities, blindness, deafness, and mongolism can often be diagnosed at birth, or shortly thereafter.

The cerebral palsies cannot always be detected so soon, but my pediatric associates tell me that if the pregnancy history and type of delivery is known, and the baby is observed carefully over a two or three weeks interval, these can frequently be at least suspected early in the life of the baby.

We have said that adequate obstetrical care is important from the point of view of the baby. And I repeat this, because it is a statistical fact that cerebral palsy occurs more commonly in

babies after a history of a complicated pregnancy or delivery.

In discussing adoption problems with my prospective parents, I like to emphasize that although it is nice to know as much about the baby as possible, they are frequently too concerned with this aspect. I believe that the prospective parents are not looking only for an addition to their home, but they are in adopting a baby also contributing to the welfare of an individual. And I think they should keep this fact before them.

I like to cite the case of my friends in New York, an obstetrician and his wife, who knowingly adopted a handicapped child, because they felt they were eminently suited to care for this child, and knew that it would not be considered suitable for adoption elsewhere. This, I think, is the true spirit of adoption.

Finally, we come to the problems of the adoptive parents. Usually but not always these are a sterile couple. I have known physicians who have considered a certain child would be best placed in a home with other children. But ordinarily we think of the sterile couple as being the most suitable for the adopted child.

The role of the physician is usually to evaluate the infertility or in other words the ability of the couple to produce a child of their own. As a background for this, I think it is an interesting fact to know that twelve per cent of all couples in the United States are judged to be involuntarily sterile. Of this twelve per cent, from twenty-five to thirty-five per cent could be helped with adequate medical care.

How is a medical evaluation of infertility made? Ordinarily it takes at least four office visits and five fundamental procedures to make an adequate estimation of infertility. The man as well as the woman must be examined, because although statistics vary from population group to population group, in the United States, it is estimated that infertility is caused by male factors in twenty-five per cent of the cases.

As psychosomatic aspects are known to be involved in infertility, it is extremely important for the physician to assess the emotional stability as well as the physical status of both individuals involved. Thus it can be seen that if the physician has satisfactorily evaluated a couple for infertility, he should have a good knowledge of their physical, intellectual and emotional capacities.

In making a prognosis, the medical factors involved in infertility are judged as either absolute or relative. The absolute factors are those which preclude a pregnancy absolutely; absence of ovum or ovulation, the absence of sperm, and tubal blockage. Such absolute factors are estimated to play a part in the infertile couple in less than ten per cent of the couples, therefore from the medical point of view, ninety per cent of the couples must be judged as relatively fertile.

But the prognosis isn't made on the basis of medical factors alone. There are two other statistical facts which help us enormously. These are, first, the duration of the marriage, and, second, the age of the individual. If the couple has been married for one year, we know statistically that they have a fifty per cent chance of achieving pregnancy. If they have been married for three years without a pregnancy, their chances have fallen to six per cent. And if they have been married for six years with no pregnancy, their chances have fallen to less than one per cent.

The age of the wife is important, for it has been shown that women marrying under the age of twenty years are only five per cent infertile. Women marrying between the ages of thirty-five and forty are thirty per cent infertile. And women marrying after the age of forty are seventy per cent infertile. Therefore after the age of thirty-five, infertility increases rapidly.

Thus, in making an evaluation of infertility, we judge the medical factors, duration of the marriage and age of the wife.

In summary, then, I can say that it seems obvious that all four individuals intimately con-

cerned with adoption have or may have major medical problems.

What is the role of the physician under the present Maryland adoption laws, when he is consulted either by the mother who presents herself pregnant asking for help, or by the sterile couple who has been judged as suitable for adoption? As I understand it, the physician can supply a list of licensed agencies—simply this and nothing more.

JUDGE MOSER: Thank you very much, Dr. Jones. Of course, the very obvious questions here, I am sure, occurred to everyone here, after Dr. Jones has given the quite scientific and absolute answer within the range of percentages which were mentioned. They are: No. 1. Is this the kind of child that would be acceptable for adoption in the normal household, in the average household. No. 2, are the couple seeking merely to supply the mother another home for the child, and can that couple be given definite advice as to whether the infertility that has brought about their need and desire, a real or a passing thing. I was rather surprised that Dr. Jones did not go further and say the medical profession can supply this home as a part of the picture.

I am sure that there are many other things that touch on the new law, the answer to which will be given by the next speaker, who is Mr. Waxter.

SOCIAL ASPECTS

MR. THOMAS J. S. WAXTER[1]

It is like Old Home Week, tonight. And I am saying this because I see at least six other people in the audience who share with Judge Moser and myself the fact that we went to Public School No. 61. Herman was the bright boy of our class. I don't know whether he still maintains this distinction. And then when I got into college I ran into Mr. Anderson. He was the bright boy in my college class. I can say this, as some indication of the age of Doctor Jones that Judge Moser, Andy Anderson and myself are old enough to be the Doctor's father.

You know that I approach our problem from a different viewpoint than Dr. Jones. The whole impetus of my feeling about children and adoption is just to focus upon the child, and forget about everything else except what is good for the particular child. The triangle of the young parent, the adoptive parents, and the care to be given the child is perfectly clear—and the only one of the three that is entirely dependent upon what we do, and the one that can have nothing at all to do with what happens to him or her is the child.

[1] Director, Department of Public Welfare of Baltimore City. (On September 11, 1953, Mr. Waxter was appointed Director, State Department of Public Welfare.)

There has been an old, old problem in Maryland about adoption. I would just like to very sketchily fill in a few gaps about what has happened in the state in recent years.

I had an old friend years ago who practiced medicine, a physician by the name of Dr. George Walker. He was a very successful physician, but he was a very aggressive sort of a fellow. I remember one time—and let us count this out, don't take it off of my fifteen minutes—he was a member of the Board of the Welfare Department, and we were going down to the City Hospitals on Eastern Avenue. On the way down we came across a small circus, and there was a man there with a balloon hitched to a rope. Walker went over to the man and he said, "How much will you charge to put me up in that balloon and cut the rope and see where we go?" The man said, $100. Dr. Walker and I got down there the next morning, at three o'clock in the morning, it was dark, and Dr. Walker, who was then in his 60s, got in to the balloon. Away they went up in the air. That evening I got a telegram from Dr. Walker, saying that he had landed up near Wilkes-Barre.

Well, it seems that Dr. Walker, with Dr. Howard A. Kelly, back about 1912 or '14,

became much concerned in Baltimore as to what was happening with babies, and particularly what was happening in the field of adoption.

They brought a person in from Philadelphia to do a study of the Baltimore situation. This man, with the help of Dr. Kelly and Dr. Walker, wrote the little book that some of you know of, called "Babies in Baltimore." They found that Baltimore was in those days called a lying-in city. Girls would come from all over the East Coast to Baltimore to have their children, and the children would be adopted out to people in the community. Baltimore was well known as the place in this part of the nation, to go to have your child, to get rid of your child and to go home. Out of the study came what was known as the 1916 Law, the Six Months Law.

The law tried to do something about people just having babies in Baltimore, indiscriminately, and putting them out to adoption without any rhyme or reason, except that it was the convenient thing to do. Under the Six Months Law of 1916, a mother had to stay with her newborn baby for six months, unless two doctors certified that it was necessary for the physical health of the mother that the mother and child be separated, or unless the State Department of Welfare certified that for social reasons it was desirable for the two to separate.

The law remained on the books until the mid '40s, '47 I believe, when the Maryland Legislature repealed it and enacted in place of it what is known, or what was known at that time as a Registration Law.

Under this Registration Law no one in Maryland could place a child with non-related people unless the fact of placement was registered. In other words, neither the mother nor anyone else could take the child and put that child into the custody of non-related people unless they registered the fact that they were placing the child with the State Department of Welfare.

The Registration law was an extremely difficult law to enforce. The Legislature in 1950, repealed it and enacted nothing in its place except to see that the adoption law was changed so that in the mind of the Legislature at least only a mother could place the child with a non-related person.

The volume of adoptions in Baltimore has grown rapidly. Gerald Monsman of the Legal Aid Bureau, made a study of adoptions for a committee appointed by Governor O'Conor in 1947. This study found that in Baltimore City roughly there were about four hundred adoptions going through each year. Of the four hundred adoptions in 1947, not quite half were with related individuals, and did not need the protection of a strict adoption law. The adoptive parents were people who were related to the mother. However, with the other half, something over two hundred adoptions that year that went through the courts, only about ten per cent were agency adoptions, and the other ninety per cent were made without the benefit of an agency.

Since then there has been an increase in the number of children being adopted, largely due, it is thought, to the fact that all over the country we have been having newspaper articles about adoptions. Life Magazine ran a series of articles about adopting children, which went through all the processes of how adoptions were made in various communities in the country. The New Yorker probably ran the best of the popular articles on adoptions in three series in March of 1951. Since the war there has been a definite upsurge in the number of adoptions throughout the nation. It is estimated—and this is the estimate of a New York agency—that approximately one out of every thousand families in America has an adopted child or adopted children. And generally throughout the country of these adoptions made, about forty per cent are with relatives and sixty per cent are with non-relatives. In total about twenty per cent are made through children's agencies.

Let me give you the reasons, as I see them, why we should have a strict adoption law. Very specifically the law should provide that where children are adopted into non-related families,

that is, where the adoptive parents are not related to the child, in every instance they should be handled through children's agencies. In other words, the only way that you should be able to adopt the child in Maryland into a non-related family is through using the facilities of a children's agency.

I know that some doctors, a good many doctors, feel that they are more competent to arrange for adoptions than social agencies. I know that there are a good many lawyers that feel that they, too, are as qualified certainly as the social worker or the doctor to make arrangements for adoptions. But it just is not true. And the reasons for it are pretty obvious.

First of all, no one outside of the licensed child care agency has the necessary implements to do a satisfactory job. As a matter of timing only, the agency has the resource for taking the child at birth and making arrangements for the placement of that child in neutral surroundings, so that the child can be studied over a period of time. And we pretty well know what kind of kid we have before any commitments are made.

Some doctors feel that they can know a good deal about a child in a few weeks. Another group feels that it takes a year, according to Dr. Jones, and she suggests that the truth may be somewhere between the two.

Well, neither the doctor nor the lawyer have any facilities whatsoever to keep that child in neutral surroundings, without any commitments being made until it can be determined exactly what kind of child we have.

Secondly—and this second point is recognized in the Maryland law specifically—the law makes it mandatory that you cannot get a consent that is binding from the mother until after the baby is thirty days old. In other words, the law takes a dim view of the matter of making a commitment before the child is born, or immediately after the child is born. Certainly the average mother who has had a child out of wedlock is in no emotional condition to make commitments that are binding upon the child and binding upon herself immediately before, or immediately after, the birth of the child. And that time factor is of tremendous significance.

Thirdly: There is no reason in God's world why the friends or acquaintances of any doctor or lawyer should have priority in being selected as adoptive parents. It is not a matter of adults having priority. The priority is for the child. The agency, a recognized good agency in the community, has a long list of possible adoption homes. And it is possible to match the child against the home out of all relationship to the situation that any doctor or any lawyer can have.

And let me say right here and now that there may be doctors and there may be lawyers who can do a highly effective job on adoptions, but this certainly does not mean the entire medical profession and the entire legal profession. And in order to rule out one person, you have to rule out the whole group.

Fourthly: It is a fact that only the agency can really follow the child and the adoptive parents over a period of time. After the child is placed with the prospective adoptive parents, there is no way for the physician or the lawyer to follow the situation for say six months or a year before any papers are filed. No one has the time except the agency, and no one has the resources to accept the child back into its care if it is found that this child is not a good risk, that it is not a good risk for the child to leave the child in that home, either for something in the nature of the child, or with the parent.

And then, and lastly, the skilled social worker who is working with infants over a period of time develops a special skill in this whole adoption process that the lawyers do not have and that the doctors do not have, and we should keep within our own areas of competence. Then, too, only the social worker can bring all the various forces and agencies together.

Now, I certainly don't go to a social worker if I am in a bad way in the criminal courts. I go to Andy Anderson. And I don't go to a social

worker if I have to have an operation for appendicitis, and I don't go to Dr. Jones either, but I go to a general surgeon.

I would like to have the community accept the fact that there is a real specialized and high technical skill possessed by the social workers' profession, and that social workers have something which is very real when it comes to working with children in the adoption process.

And finally I believe far more—and you, Dr Jones, have convinced me of this—that the agency, of all the ways in which children can be adopted, the agency is going to be the place where the focus is upon the child, it is not upon the mother, it is not upon the adoptive parents, but it is on the child, and what is best for that kid. This is what I am pleading for, regardless of what the present law may be.

And I would like to make a suggestion, and that is that the Bar Association and the City Medical Society appoint a small joint committee, infiltrated with a social worker or so, and that the committee try to draw the kind of adoption law that we want for Maryland and then go down to the Legislature and see that children are properly protected.

JUDGE MOSER: There is no such thing as permanence or perfection, and there is certainly no such thing as permanent perfection. And I am perfectly sure, for that good reason, that the law of 1950 could well stand, as was suggested by Mr. Waxter, a going over, a looking at, and a careful examining, and perhaps that may give us something that is better.

There were several thoughts that occurred to me as Mr. Waxter was speaking. The main and really the only point involved in the saying of "yes" or "no" to an adoption is when is it best for the welfare of the child. And then why is there any distinction, or why should there be any distinction between related and unrelated adoptive parents? If the only question that should be before the court is the welfare of the child, then why can a mother determine that without aid better than anyone else?

I am just posing those questions. I don't know whether they are good questions or not, but obviously there are many ramifications to this.

I am aware of the thirty days period that you speak of after the birth of the child that would invalidate consent, but I also am perfectly sure that a court would take into consideration, if a mother filed a petition to set aside her consent before the birth of the child, or on some period after 30 days if her circumstances mentally were such that she was not aware of the full implication of what she was doing.

There are some other things, but I will wait for the question period for them.

We are now about to hear from one of those who admittedly, I am sure, will tell you that he is not qualified to say whether or not a child should or should not be adopted, but whom I am also sure, from recent experience I had with him in court, has some very positive ideas as to whether or not this law is the right or correct way of going about protecting the interests of the child, and whether or not the law is a good law, and whether or not it is even a constitutional law.

We are now going to hear from Mr. Anderson.

LEGAL ASPECTS

G. C. A. ANDERSON, ESQUIRE[1]

Judge Moser, members of the Panel, Ladies and Gentlemen:

I am not here to attempt an evaluation of the various social factors that may be involved in this particular question. I am here for one special purpose. I feel strongly about that purpose.

I want the public to understand the drastic character of the law now in force and effect in Maryland, and more particularly, I want doctors and lawyers to understand their rights, duties and obligations under that law, being Chapter 63 of the Acts of 1950 of the General Assembly of Maryland.

My story starts in 1945. In 1945 a delegation from Montgomery County went to the Legisla-

[1] Past President of the Bar Association of Baltimore City.

ture; this delegation urged the Legislature to amend the existing adoption laws. Montgomery County is near Washington, and the County was having trouble with the adoption laws, and the adoption of children. During the same session, a delegation from Baltimore visited the Legislature. This delegation also wanted to make some amendments to the adoption laws. The two delegations decided to pool their resources. Under their sponsorship a Resolution was passed by the House of Delegates under which a committee was duly appointed by Governor O'Conor, headed by His Honor Judge Eugene O'Dunne of the Supreme Bench of Baltimore City, as Chairman, and Mr. Gerald Monsman of the Legal Aid Bureau, as Secretary. This Committee was directed to make a study, report to the next Legislature, and propose for enactment by the Legislature such laws as the Committee deemed advisable.

The next Legislature in 1947, at the suggestion of this Committee, enacted Chapter 599 and Chapter 600 of the Acts of 1947. For the purposes of this discussion, I am only interested in Chapter 600.

It was the purpose of this Act to grant the State Board of Public Welfare rather complete authority and jurisdiction over the adoption and custody of unwanted and homeless children. Specifically it provided: (a) that all agencies or individuals having the care, custody or control of minor children; (b) that all institutions and individuals who act as child placement agencies for adoption, and (c) all individuals who regularly engage in the business of providing foster homes, were required to have a license. The law went on to provide that all individuals or agencies violating these provisions of the Act were subject to a fine or prison sentence. Thus we start with the theory that any person acting as a placement or adoption agency must have a license.

You will note two significant facts about this Act. The Act generally would control the adoption of children through the licensing of adoption agencies, but it did not specifically prohibit a mother from arranging for the adoption of her own child.

As might be anticipated, the Act was difficult to enforce. The prohibition ran against a "placement agency." A distraught mother and lawyer, or a distraught mother and doctor or clergyman was scarcely such an agency.

What happened? As you have already been told by Dr. Jones, in a first pregnancy, the mother is often unduly worried and frightened. To this add the fact that she is unwed. Often, in a near panic, she asks for help. Her request may be directed to her doctor, a member of her family, a lawyer to whom she turns for advice, or a friend. It often takes the form of "Can't you find somebody who will adopt my child?" If a home is found for the unwanted child by the mother with the help of her doctor or lawyer, such action by the mother in an isolated case, or by a doctor or lawyer in several cases, scarcely turns the mother and the doctor or lawyer into a placement agency. Since placement agencies alone were prohibited from the placing of children without a license, it followed that many children placed by the mother, with the help of a doctor or lawyer, were adopted without a license.

For good or for evil, it was believed that this was a serious defect in the law. The matter was brought to the attention of the Legislative Counsel and the present Act, being Chapter 63 of the Acts of 1950, was the result.

This Act of 1950 provides as follows:

> "... the placement of a child by anyone other than a licensed child placement agency, local Department of Welfare"—[and here is the joker]—"or the child's natural parent or parents, grandparents, or the child's natural parents, adult brothers or sisters, is prohibited."

Thus ... adoption of children is prohibited unless ... done through a placement agency or, ... quote, "the child's natural parent or parents."

It was very kind of Dr. Jones a moment ago

to say that children could only be adopted through placement agencies. When I first discussed this law with her, she advised me somewhat as follows: "You don't know what you are talking about, here is what it says—it says that the child can be adopted, or can be placed by a natural parent."

But the question is, what does the Act mean when it says there can be a placement of the child by the child's natural parents, grandparents, adult brothers or sisters?

The Act is primarily a model Act. It had its origin in New Jersey, and has been copied by some seven or eight different states along the Atlantic Seaboard, including the District of Columbia.

The leading appellant case is to be found in the District of Columbia, and is known as the *Goodman case*, reported in 50 Atlantic (2d) 812.

In this case, a woman went to a lawyer for the purpose of getting a divorce. She was pregnant at the time, and wanted to be sure her child was placed in a good home. She requested her attorney to look for a home. He refused, but suggested that she go to one of several recognized placement agencies in the District. She had been brought up in an orphanage and apparently was fearful of such agencies. At any rate, she refused such advice, and persisted in requesting the attorney to assist her. The record in the case shows that approximately twice every week this woman called the lawyer requesting him to look for a home for the child. He persistently refused her request.

She was about seven months pregnant when, becoming desperate over her situation, she insisted that her attorney take some action in the matter. He finally acceded to her request; he looked around and found some people who were interested in taking this child. He arranged for the adoption. The child was adopted. And that was that.

Some time went by, and the natural mother changed her mind, brought the matter to the attention of the authorities, and the lawyer was indicted for violating the law, in that, he had been guilty of an act of placement. It was admitted that he did not get a dime for what he did. It was further admitted that everything he did, he did for purely humanitarian purposes. It was further admitted that everything he did, he did only because of the mother's insistence.

The court held that motives were immaterial, that since he had assisted in the placement of the child, such assistance constituted a violation of the Act, since a child can only be placed by a placement agency, or the mother acting alone without the assistance of any one. All of which means that the mother herself must contact the adopting parents and conduct all the arrangements leading up to the adoption. To aid or assist the mother is to violate the law. At page 814, the Court said:

> "... that Appellant (the lawyer) did these things without compensation, that he was animated by the most humane motives, that he was perhaps imposed upon by the mother or yielded in sheer pity to her cries of distress—all this we may concede. *And all this appeals to our sympathy for him; but it cannot justify us in holding that his acts were within the law.*" (italics supplied).

Such a law violates a rather general pattern of conduct that has been followed in Maryland for a great many years. It has often been the custom and habit of doctors and lawyers, if asked by the natural mother, to place or arrange for the adoption of the child, or at the very least to aid and assist in the adoption, after some one else has made the contact between the mother and the adopting parents.

Lawyers did it, doctors did it, and probably many other people, acting with the best of motives, participated in the adoption before it was concluded. In the more rural counties of Maryland today, the law is honored in its breach.

There was a recent case in Maryland which went to this extreme. A Maryland doctor was visited by his brother-in-law from New York. In the course of conversation, the brother-in-law remarked that the doctor, in the course of his rather extensive general practice, might know of

an unwed mother who wished to place her child in a good home; that he had some friends who had been married for ten years and who were very anxious to adopt a child; that should such a case be brought to the attention of the doctor, would he be good enough to drop him a note. Without thought, the Doctor said he would. Some time went by. I have forgotten exactly how long,—perhaps a year or a year and a half, when the Doctor, in the course of his practice, was called to treat a woman who was very anxious to obtain a home for her unborn illegitimate child. The Doctor wrote his brother-in-law, and shortly thereafter received a long distance telephone call from the married couple who wanted to adopt a child.

Over the week-end, this couple came to Baltimore and the entire matter was investigated and discussed at some length. The child was born and the Doctor notified the adopting parents. They wired the Doctor that their lawyer was coming to Baltimore. He met the lawyer, introduced him to the mother, and the adoption was arranged. That is how a contact was made. He was indicted, tried and found guilty of violating the law.*

My point is that I want the public, the doctors, and the lawyers to understand the drastic character of the law. To date there has been in Baltimore this one case under the new law, which case was in the nature of a test case. This test case has placed the public, the medical profession and the legal profession on notice. Ignorance is never an excuse, and henceforth it cannot be used as an excuse even to mitigate punishment.

Thank you very much.

* For further discussion of this matter, see Daily Record of sixth day of April, 1953.

JUDGE MOSER: Ladies and gentlemen, we are going to have a very few minutes recess, but before we do I would like to make several comments.

I am in thorough accord with what has been said by all the speakers, and particularly by Mr. Waxter and Mr. Anderson—in their comments on the law, that is—that it is probably not understood.

I must confess that when the first case was brought before me, I was distinctly surprised to find out that was the law. I had no idea that it was. I could be wrong about it, too. At least, that was my best guess.

And in looking around, I am hoping that none of you came here this evening for immunity, but for information.

However, before we feel too sorry for some of those who have violated this law—and may I confess also that unlike Mr. Waxter, who can speak of his association and championship of the Department of Social Service and Social Service for Children here in the community, for which the community should be eternally grateful to him—unlike Mr. Waxter, who said he has no bias for social workers, I confess that I have a bias for lawyers —but not for the lawyer in this particular case who, according to the information which I have, went to doctors, and received fees up to $4500 for producing babies for adoption.

We are going to have a four or five minutes recess, wherein those members of the audience who desire to write out questions which they would like to have answered by any of the discussants may do so. Mr. Waters, if you will sort of separate them, then we can discuss them. So we will recess for just a few moments.

(A short recess was then taken.)

QUESTION AND ANSWER PERIOD

JUDGE MOSER: Take your seats, so that we can continue.

I am delighted at one thing, and that is we have received many more questions than we will have time to give you the answers. I am delighted that you have asked so many questions. Unfortunately, if we don't answer the particular questions which you desire the answers to, I want to apologize for that fact, and I want to assure you that it is not because we do not want to, but because we have not the time to answer your questions.

I would like to inform the discussants that they will be allowed, except by special dispensation, three minutes to answer each of these questions. I have several here that I wanted to

start something with, but I am going to submit those in just a little while. I am going to get these other things out of the way first.

Q. There are two questions that can be asked together. One, "Please state the list of placement agencies that the doctor may mention to the mother," which I think is an excellent question, and along with that is another question which is along the same line, but which goes a little farther, and that is, "Please give the method, step by step, whereby one without violating the law"—and that means a doctor, or a lawyer, or an individual other than the mother —"whereby one without violating the law may take part in the adoption process?"

I think, Mr. Waxter, I will let you give the answer to this. I know you are more familiar with the placement agencies than any of the other discussants.

MR. WAXTER: In Maryland, a child placement agency must be licensed by the State Department of Welfare. In other words, an association goes to the State Department of Welfare, files a request for a license, they are studied by the Department, and then a license is granted.

In Baltimore the three big private agencies are The Jewish Family and Children's Bureau, the Associated Catholic Charities, and the Family and Children's Society of the Community Fund. Probably the Church Mission Society, which is an organization of the Episcopal Church, provides for as many adoptions as any of the smaller organizations. And the Department of Welfare of Baltimore City also provides adoptions service.

Individuals can be directed to any of the agencies that I have mentioned. There are others besides those I mentioned. They are listed by the State Welfare Department.

Under the present law, there is nothing to stop a mother herself in making all arrangements for adoption and in doing everything that she can up to the time that the petition is filed in court. Under the present Maryland law, the mother has complete freedom in placing the child anywhere she wants to, but the difficulty comes, as I understand it if in any way a doctor or a lawyer, no matter how innocently, participates in the matter of the selection of that home, or having anything to do with the home.

Isn't that right, Andy?

MR. ANDERSON: That is right.

MR. WAXTER: I think that is really the essence of what you say.

And I think the proper way, step by step, is for the mother to go to a social agency, to work with that agency that already has a list of the possible adoptive homes and to work with the agency towards having her child placed, if that is the desirable thing for the child and for the mother.

Now, let me interject this one thing. There are a great many mothers, small percentage wise, but in the total nation large in number, who, if they made the decision, if they were forced to make a decision immediately before birth, or immediately after birth, would put their child out for adoption and release the child, but who actually, when they don't have to make a decision of that kind, work out some arrangement by which they keep the child with them, in other words, no adoption comes into being, because the mother has time enough to consider the whole problem and decides to keep that child with her.

JUDGE MOSER: Incidentally, Mr. Waxter, you answered the question by asking a question of Mr. Anderson. And one of the other questions was whether the introduction by someone other than the mother to the adoptive parent is a violation of the law. And it could very well be, as Mr. Anderson indicated.

Now, I would like to ask you several questions, Doctor, if you don't mind coming around here. I think if you will, we can all hear you better.

There are several questions here that I have been asked to ask you.

Q. The first question is, "Is there any medical evidence for the popular belief that the adoption of a baby is a cure for infertility?"

DR. JONES: That is one of the most frequent

questions asked in a discussion of infertility. There was a study made on this subject two years ago in Boston. The answer is, no, there is no statistical evidence that adoption is a cure for infertility. Those individuals who adopt children have no more chance of having children of their own than infertile couples who do not adopt them.

Q. JUDGE MOSER: Now, I think I am going to start a little difficulty here. It is a little off the subject. But I am sure it is one about which the Doctor is very familiar. The question is, "Is artificial insemination practiced in Maryland, and what procedures are followed in its practice?" And I am telling Mr. Anderson that I am going to ask him another question thereafter, which I think is connected to it, "What legal implications may arise from the practice of artificial insemination?"

DR. JONES: Yes, artificial insemination is practiced in Maryland.

I think we should define artificial insemination, because actually there are two types. One is with a donor's semen and the other type of artificial insemination is with the husband's sperm.

The latter is practiced I think in Maryland much more commonly than artificial insemination with a donor. But it also is done. Although there is a wide difference of opinion as to the advisability of this. I think that certainly the physicians in Baltimore who do this do it only at the request of both individuals—the husband and the wife. I think it is also a procedure that is usually not suggested by the physician. I personally would never consider suggesting it. But I have done it on request.

It is asked, what procedures are followed. Does that mean medical procedures or law procedures?

JUDGE MOSER: Medical. Unless you care to go out on the limb.

DR. JONES: Artificial insemination with the husband's semen is practiced only when there is some anatomical abnormality, or some reason to believe that with a concentration of semen the sperm count may be sufficiently raised to effect a pregnancy. It is quite a technical medical procedure.

In donor artificial insemination getting the donor is the major difficulty, because we must be assured that the donor is a superior person with a good medical background. One must go into his history just as you would your patient's history. You have to know whether he has any congenital abnormalities in his family, or any hereditary diseases such as diabetes, as we prefer to use only men who have high contributions to make. This, of course, makes procurement very difficult. We ordinarily recruit our donors from the hospital staffs or medical schools.

It is always surprising to me how reticent men are about making such contributions. And I think it is an excellent characteristic. It shows their feeling of responsibility to their progeny. Even though they may never know them, they still feel a great personal pride in this, and I think it is a good thing.

When I perform artificial insemination, I use three donors on three separate days, so that I don't know actually who has made the successful contribution. And I don't keep any records of any donors, either.

Another thing that I always do, and that is recommended by the American Medical Association: I have a little paper which I get both the husband and the wife to sign, saying that they are fully aware of what has taken place and that the child will be legally adopted. I understand that it is important that the child be legally adopted to clarify its status.

Does that answer the question? There are many aspects to this.

JUDGE MOSER: I am sure that it was interesting, at least to the legal part of the audience, who have little knowledge of it. It is the kind of topic, too, perhaps about which no comment should be made except by those who know about it.

Q. Now, Mr. Anderson, do you care to comment about some of the legal effects that might flow from this? In fact, another question that is

asked is with reference to the legal status of a child conceived by artificial insemination, which I think was answered by the Doctor, in which she said there are adoptive procedures which remove the possibility of there being any question as to the status of the child legally.

Incidentally, do you feel you are on the hook a little bit here, because you were not aware of this? And if you want to think about it for one minute, there is another question asked that you may answer in connection with this one, and which has absolutely no connection with it, "What specifically are the changes which you would advocate in the law which you say is of such a drastic character?"

MR. ANDERSON: Well, I will take the first one first.

I know of no actual case. There was a paper delivered to a panel somewhat like this panel in Chicago, the gentleman who delivered that paper made the same kind of a general statement that I am about to make.

You must remember that when dealing with adoption, you are dealing purely with statutory law. All rights that flow from adoption proceedings are a result of statute. Adoption is unknown to the common law. It was known to the Roman law, but unknown to the common law. Therefore, there is no common law precedent. Thus, whatever the rights, and whatever the duties and obligations, they must be determined by statute.

I am sure that when the adoption statutes were passed, the original statute in Maryland was passed in 1892, nobody had any thought in mind of this particular kind of problem.

It was the conclusion of the gentleman who read the paper in Chicago, and I think it is a proper conclusion, predicated again on the statutes themselves, that the status of the child would probably be that of a bastard. As a bastard, of course, he would lose all the rights which attach to a natural child, as distinguished from a bastard child. I believe that under those circumstances, the only safe thing to do, and it apparently is the practice, is to later have the child legally adopted, to be sure that the child has the status of a natural child.

Q. The other question was: What would I do about the law in Maryland if I had anything to do with it?*

Well, I don't know just what I would do, except I would try to clarify the Act so that any one reading the Act could clearly and easily, from the terms of the Act itself, know what was a violation of the Act and what was not a violation of the Act.

Because of what I believe to be its ambiguity, I have argued strenuously with Judge Moser that the Act is unconstitutional. It is a fundamental constitutional concept that you are supposed to be able to look at a statute, and particularly a criminal statute, and know whether you have violated the same.

If the Act is as drastic as the Courts have interpreted it to be, then it seems to me that the statute itself ought to be crystal clear. That, I submit, is not the case with the present Act.

Q. JUDGE MOSER: Before you sit down, Mr. Anderson, do you mind answering this one other question? "What is the law as it affects the adoption of a person over twenty-one?"

MR. ANDERSON: People over twenty-one can be adopted exactly the same as people under twenty-one.

The age of the person has nothing to do with it.

Q. JUDGE MOSER: Mr. Waxter, I have a question here that I think is one that you are probably in a position to answer. The question is, "What specifically is the special skill that a social worker acquires—what tests do they use on infant children to determine their adoptability?" I put that question to you, Mr. Waxter.

MR. WAXTER: I would like to say a few words about the new adoption law.

* Governor McKeldin has recently appointed a Committee, with His Honor Judge Moser, Chairman of this Panel Discussion to study the adoption laws and make such recommendation as it deems proper.

If we are going to have a new adoption law, I would like to see the best minds in the law and in medicine and in social work sit down and consider the problem of adoption, yes, but adoption, after all, is only one method that we have evolved in society for taking care of a large number of children who either have no homes of their own, or who need homes other than the homes that they have—adoption is one method of doing that—and it takes care of and drains off a few of the children who do not have proper homes of their own.

Now, then, along with any adoption law, we should have in Maryland something that protects the large number of children, probably more than are adopted in any one year, who are living outside of the circles of people who are kin to them. There is a lot of passing along of children in Maryland, and certainly a lot of it in the Negro communities, where somebody has a child and they give it to somebody else, and there is never a formal adoption process that takes place. I think we ought to sit down and find out what the State should give to children in the way of protection, so that when they go to live with unrelated people, that the State knows what is going on, and that the State has some assuredness that the kid is getting an even break in life.

That was the thesis of the Six Months Law, to give time to consider the whole matter, and make it necessary for two doctors or for the State Department of Welfare to say that the mother should be separated from the child. It was certainly the object of the Legislature that no child could be placed with a non-related person unless the fact was noted and registered with the public authorities. This Act was wiped out without putting anything in its place. It is wide open as of the present time. We should have something in the law that stands side by side with the adoption law, that would guarantee to children that when they are placed in a home by their mother or by anyone else that the State looks at that situation, to be sure that the child gets minimal protection.

Now, let us go back to what skill the social worker has that a lawyer does not have and a doctor does not have. It is the same thing as asking the doctor what does the doctor have and what is the science of medicine and the same thing as asking the lawyer what is the science of the law. And here I may say this to you, that there are skills in working with people —and certainly all of you know this—there are skills in working with people that have been developed as a process over the years, and there are ways of understanding children and working with them and developing a technique that can be very useful and effective.

One of the difficulties with social work it seems to me is the inability to put into precise words what social case work means; what it means to understand people and to help them work out their problems by understanding the problems of the individual and helping him.

I would like to have that answered much more adequately than I can answer it. I would like to have it answered by a professional social worker. There are a lot of them in this room.

Q. JUDGE MOSER: Before you sit down, here is another question that was asked, "Would it be good policy, that social agencies give preference, all things being equal, I presume, considering the welfare of the child, to those parents who are not fertile?"

MR. WAXTER: Let me say this. The Baltimore Council of Social Agencies publishes a quarterly. The last issue was in December of 1952. They had three social workers in Baltimore who wrote in the December issue about adoption: one from the point of view of the real mother, one from the point of view of the child, and one from the point of view of the adoptive parents. These articles do an awfully good job in presenting the points of view of the three corners of the triangle, and what social work does in trying to work out what is best for all three parts of the triangle, but with the prin-

ciple focus on the child. This publication is available to anyone interested in the problem.

Frankly, I don't see why any group of potential adoptive parents should be given priority over another group. The thesis that I am trying to develop is that the focus should always be on the child and not on the adoptive parents. And no one ought to have priority in this matter of adoption except the child itself.

Q. JUDGE MOSER: There is a question that was handed up, and as it was passed along, in all seriousness, I assume that someone desires it to be answered, but whom I should ask to answer it I am somewhat at a loss to determine. It says, "Who would you consider the father in the illustration cited by Dr. Jones, of the three donors?"

DR. JONES: I can answer that.

JUDGE MOSER: I will permit you to answer it, Doctor.

DR. JONES: I consider the father the man who has made the largest contribution—the husband of the wife.

JUDGE MOSER: There are many, many other questions that have been submitted, and I am sure that it would be quite interesting to get the slant of the discussants on many of them. For example, "Is it a good psychological policy for the real mother and the adoptive parents to know each other?" Of course, normally they don't know each other. Normally, they don't come in contact with each other.

Here is another question that was asked, which points out some of the things that are done. The question was, "What information does the court have before it when it signs the adoption papers?"

Well, the court has all the background that has been discussed by Mr. Waxter and by Dr. Jones. It also has its own agency, it has its own probation department, which makes an investigation and which reports thoroughly on all of the aspects—the health of the child, the health of the adoptive parents, the reason for the mother wanting to have the adoption occur. And it is a very voluminous and very thorough report.

I see in the audience here one of those who has the responsibility for seeing that those reports are as thorough and are as carefully prepared as they are—Mr. McDermott of the Circuit Court, for Juvenile Causes, where the investigations are now made when the court is asked to sign the adoption decree.

Of course, there is no law, as I say, that cannot be improved upon. And perhaps out of this discussion this evening may come the necessary impetus to do two things, as I suggested at the beginning.

First, to make sure that those who come in contact with persons who desire to avail themselves of the law—and primarily the doctors, the lawyers, and social workers—thoroughly understand the law with which they have to deal. You may say that it does not seem right, that a grandparent or a brother or sister be in any better position to place the child than a placement agency. And they are questions that serious-minded persons may well discuss, and it may be that out of these discussions will come a better understanding of the law as it is.

And, secondly, I believe that if a better law can be placed upon the statute books, then I am sure that the community will owe a debt of thanks, not only to these discussants here this evening who have helped to bring it to you, but to the two Bar Associations and the Medical and Chirurgical Society that have made this interesting evening, to me at least, possible.

I thank you.

Scientific Papers

MANAGEMENT OF CONVALESCENCE AND LATER LIFE AFTER CORONARY THROMBOSIS*

WILLIAM S. LOVE, M.D.†

Coronary occlusion is said to be present in 40% of all autopsies in males above the age of 50. Such occlusion may have symptomatically appeared explosively with myocardial infarction but, except when due to trauma in younger individuals or to the rare case of embolism, the underlying disease process has been of gradual development. This process is arteriosclerosis of the coronary arteries. Certainly in most instances it has been present long before myocardial infarction may have occurred. This fact should influence our thinking in two ways in regard to the patient who has suffered infarction—first, that he has offered definite evidence of the existence of chronic arterial disease that will persist even though the acute symptoms subside, and that may again undergo acute exacerbations; and secondly, we may be cheered somewhat by the thought that many others in the patient's age group also have arteriosclerosis, but will never suffer clinically acute myocardial infarction—perhaps it will not occur again in our patient.

Let us consider the patient who has made a good clinical recovery from myocardial infarction and who has no complications. It would seem obvious to me that our objective should be to get him back to as normal a life as rapidly as possible as is consistent with a reasonable degree of safety. The average patient who is doing well can be permitted moderate activities such as moving about freely in bed, using a commode etc. from the beginning, and can usually leave the hospital by the end of his third week, if not sooner. To keep such a patient indefinitely at rest at home only encourages the development of fears and apprehensions that may be more crippling than the condition for which he is being treated. Therefore, in this type of patient, I like to have them back at part-time work not longer than two months after the onset of the illness, providing such work does not entail any strenuous physical activity. Furthermore, some degree of activity promotes the development of collateral circulation between the branches of the coronaries—indeed, such collateral circulation develops in response to the narrowing of the arteries by sclerotic placques, and if occlusion takes place gradually, may be functionally adequate to prevent infarction. However, I prefer that they not participate in any physically active games, such as golf (never tennis) for at least a year. By that time what anastomosis between the coronary arteries that will develop can be expected to have done so. These activities should be permitted only to those who have no complications and no apparent limitation of cardiac reserve.

In these patients I believe that there are several ways of attempting to prevent recurrence of the infarction. First, they (and probably all of their age group if over 50) should avoid strenuous or violent physical exertion, or exertion of an unaccustomed degree. The majority of sudden occlusions of the coronary arteries are attributable to small subintimal hemorrhages which increase the size of arteriosclerotic placques, and may lead to thrombus formation

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distal to the point of narrowing. Contrary to earlier thought on the subject, most now agree that preceding such a train of events, a history of unaccustomed exertion, excitement, a blow on the chest, or other injury is usually present. Who of us hasn't seen such a case as this: a four or five inch snowfall overnight; the patient tries to shovel his way out of the garage; hurried and probably angry, he has a sudden crushing pain in the chest and has to sit down. In a few minutes he may feel all right and go to his office, only to have the pain return more severely hours or even a day or so later and when finally examined infarction is discovered. Therefore, these patients should be warned that as far as possible they should avoid such precipitating factors. Take the time to explain the situation to them. An understanding patient is usually a cooperative patient.

I sometimes think of Christmas as the infarction season: overactivity, parties, late hours, and gluttonous eating. Another history I am sure that we have all heard is one that concerns the big dinner, the afternoon party and then the stop at the brother's home for a little snack and some beer—and often what a snack—and the awakening at four or five in the morning with indigestion that turns out to be infarction. Needless to say, these patients should be advised as to the possible consequences of such living, and advised to live normally and to eat modestly.

Another question in regard to diet and metabolism is being very actively investigated at present: this is the relationship of cholesterol and related lipids to the production of arteriosclerosis. It does not seem likely that cholesterol is the initiating factor in the causation of arteriosclerosis. However, it is quite possible, even probable, that disturbances in lipid metabolism with excessive blood concentrations thereof, lead to an increase in their deposition in the arteriosclerotic placques with consequent greater narrowing of the arteries. Therefore, I certainly believe at present that it is wise to advise low cholesterol, low fat diets in these patients; when overweight an active reducing regime is indicated and relatively low calorie diets are indicated in all such patients. The liver produces cholesterol and will do so on high calorie intake.

Now, all that we have discussed probably involves some restrictions of previous activities. I would like to suggest that you present these restrictions as a matter of sensible normal living, perhaps in contrast to a former abnormal way of life; that they are things that his friends who do not know that they have coronary disease would be better off for doing. While there occasionally may be times when one is justified in trying to frighten people into carrying out advice, this approach has a seriously deleterious effect on many.

The question next arises—are there any drugs which are of benefit? In the uncomplicated case, I doubt it. We will discuss in more detail such drugs as the nitrites, aminophylline, etc. when we speak of angina pectoris. We all use them in the hope that they may cause increased coronary flow and perhaps more rapid development of collateral and anastomotic channels; there is little evidence that they actually do so. Certainly, in uncomplicated cases, there is little reason to continue them indefinitely. That leaves us the anticoagulants. In my rather limited experience in using these drugs in the hope of preventing further episodes of infarction, I have not been impressed by their usefulness, and I believe that the majority of Cardiologists feel the same way. In amounts that may be considered safe for use away from daily prothrombin checks, there is little reason to believe them effective. Recall if you will that the acute occlusion usually begins with a subintimal hemorrhage. On several occasions in my experience, fresh infarction has occurred when the prothrombin time was adequately controlled by dicumarol. Even in the acute stage of infarction the value originally assessed to them is being questioned by some.

In regard to alcohol and tobacco, opinions vary. I do not feel that alcohol has been proved to be of value in dilating the coronary arteries—on the other hand, in moderation it is not harmful

and may produce a feeling of relaxation and well being. During an acute episode, I try to forbid tobacco, but if the patient insists on smoking, it does not seem to me to be worth arguing about, and the argument succeeds only in creating emotional tensions.

The complications that are most apt to occur after an episode of infarction are:

1. Angina Pectoris—This symptom of coronary disease may have been present before the infarction occurred, or it may appear for the first time afterwards; or it may never be present. It indicates a recurring ischemia and is handled in about the same fashion under either circumstance. To my mind the most important matter for the doctor to consider is what brings on such attacks, and then have the patient avoid the precipitating factors. However, it is rare that anginal episodes can be completely avoided in a patient subject to them. For immediate relief, no new drug surpasses nitroglycerine. Other mixtures of nitrites, aminophylline, theobromine salts, Khellin, papaverine, etc., often seem to cut down the frequency of attacks and are worth trying, but they usually prove to be disappointing in the long run. Certainly reliance should not be placed upon them to the point of forgetting common sense advice to the patient. In the unfortunate patients who may become practically disabled by pain, surgery is not contraindicated, and such procedures as dorsal sympathectomy, production of a sterile pericarditis, or arteriolization of the coronary sinus should be considered. Remember that sympathectomy is not known to have any influence on the underlying disease—it merely interrupts the pain pathways and thus relieves a symptom. The production of a sterile pericarditis may effect a sufficient collateral circulation to be helpful. Arterialization of the Coronary Sinus is a serious operation that has given some dramatic results. To date it has not been performed with sufficient frequency and patients have not been followed for a long enough time afterwards to permit sound evaluation.

A train of symptoms often mistaken by both the doctor and the patient for pain of cardiac origin is the Shoulder-Arm syndrome. This consists of pain in the regions named, at times spreading to the chest, usually, in the patients discussed, occurring on the left side; the condition occasionally ends in obvious trophic disturbances of the hand and arm. In mild form, it is commonly noted after myocardial infarction and is differentiated from angina by its constancy, lack of relationship to effort, etc., and by pain on motion of the affected part. It can usually be controlled by the aspirin family, by local applications of heat, massage, and especially by encouraging the use of the arm and shoulder. If very severe, sympathectomy may become necessary. Cortisone has given contradictory results in the hands of different observers. It is important to reassure the patient that this is not angina pectoris.

Congestive heart failure may occur during the period of acute infarction, or it may come on later with increased activities or subsequent to progressive myocardial fibrosis. It should be handled as usual, except that one might express a word of caution in regard to the very rapid digitalization of such patients. They should be digitalized, but it is far safer to take a little more time to accomplish full digitalization—say 24 to 48 hours. These patients also require that careful consideration be given as to what activities are permissible.

As a result of extensive infarction, myocardial aneurysm may develop. It is worthwhile recognizing this, for in my experience these patients are more apt to develop other complications, such as failure or ventricular arrhythmias, and hence should be watched more closely. Such aneurysms may also be the source of embolization. I am seeing four such patients at present, and all have had episodes of failure; in two the failure occurred acutely during attacks of ventricular tachycardia. Nevertheless, at present they are all working at least part-time in executive or physically non-strenuous occupations. The Cardi-

ologist can usually recognize this condition with his customary tools—the electrocardiogram and careful fluoroscopy.

A word about the arrhythmias is indicated. When auricular fibrillation occurs, bed rest and digitalization, if not already accomplished, will often lead to a cessation of the arrhythmia. If it does not, the situation is usually not serious for the ventricular rate as a rule can be satisfactorily controlled by digitalis; hence, I only try to restore sinus rhythm with drugs such as quinidine, when the patient's disability is obviously enhanced by the disturbance in rhythm and the ventricular rate cannot be controlled. Such patients are often difficult to "break," revert to fibrillation easily and may require maintenance dosage of quinidine that exceeds the bounds of safety. On the other hand, the paroxysmal tachycardias, because of the rapid ventricular rates which of themselves tend to enhance coronary insufficiency and may also bring about acute left ventricular failure and pulmonary edema, should be terminated as promptly as possible. For this purpose mechanical procedures such as carotid sinus stimulation may promptly end the arrhythmia; more often they will not. Quinidine still remains the most useful drug and may be given intravenously if the situation is critical. Pronestyl may be more effective if the tachycardia is known to be ventricular in origin and can also be used intravenously. I have had considerable success in the ventricular tachycardias with the intravenous use of suitable digitalis preparations; they can not be so used if the patient is already digitalized. I prefer one of the more rapidly eliminated glycosides, such as Ouabain.

Just a word about these patients and other illness. They have a lessened myocardial reserve and should be put at rest during an illness of any consequence that may throw an additional burden upon their circulation. They tolerate surgery less well than normal people, but necessary surgery should be performed. Perhaps I might mention one type of disease specifically—gall bladder disease. Correction of a diseased gall bladder has often improved the symptomatic status of these patients. I clearly recall two patients with past infarction, and frequent, but not severe episodes of pain not to be clinically differentiated from angina. Both had cholelithiasis, and both were completely relieved of pain following removal of the gall bladder. One died a year after operation during a second major infarction, and the other was living three years after the operation and was still free of pain.

Finally I would like to say a word about the electrocardiogram in these patients. All too often a patient tells me that his doctor has said he could do this or that, if the electrocardiogram has become "all right." Following an acute infarction the electrocardiogram may again become quite normal. On the other hand it may remain grossly abnormal indefinitely and yet the patient may be doing quite well. I think it is probably true that the greater the damage, the more apt the electrocardiogram is to remain abnormal. Nevertheless, we can not determine the functional capacity of a heart by the pattern of its electrical activity; your other observations of the patient are of more value in assessing his physical capacity than is the electrocardiogram. However, it is probably wise to recheck the electrocardiogram from time to time for significant changes that may occur without co-existing clinical symptoms. The converse of this statement is also true—significant alterations in symptomatology may occur without accompanying electrocardiographic changes. It is just as important to note that a patient who could walk ten blocks without angina, suddenly, is able to walk only two. Very probably there has been further occlusion and a period of rest may enable the collateral circulation to take over the additional burden, whereas maintenance of customary activity might end in further infarction. The sudden onset of angina where it has not previously existed also should lead one to think of further occlusion and should be treated by rest and other appropriate measures. Here, perhaps, treatment with anticoagu-

lants might prevent the thrombosis that may follow a sudden increase in the degree of occlusion. The period of rest, however, need not be more than ten days to two weeks unless infarction does take place. Other symptoms such as paroxysmal dyspnoea or a sudden diminution in exercise tolerance should be evaluated in a similar fashion. Let me say at this point that I do not do stress tests where the electrocardiogram is already abnormal, or immediately after a distinct change in the patient's symptoms.

In concluding this discussion, I would reiterate what I said in its beginning—your objective in the handling of a patient who has had myocardial infarction should be to return him to as near a normal life as is consistent with a reasonable degree of safety. The term normal life certainly does not include activities that are unwise for anyone in the patient's age group. Your clinical judgment in assessing a patient's physical capacity cannot be superseded by the use of "gadgets." Remember also that emotional stresses and strains can play an important role in the symptomatology of your patient, perhaps especially in regard to the frequency of anginal episodes.

THE TREATMENT OF PULMONARY ABSCESS*

R ADAMS COWLEY, M.D.†

The purpose of this paper is not to discuss the etiology or pathology of lung abscess, nor which antibiotics to use for the specific type of organism encountered. It is instead an outline of treatment of lung abscess, once the diagnosis has been made.

Pulmonary abscess is not a medical problem nor is it a surgical problem, but a combination of both. It is an unpredictable disease with ever present surgical possibilities, and the best results are obtained by a physician and a thoracic surgeon working as a close team. Most clinicians believe that pulmonary abscess is a disease of aspiration rather than embolism. It has the characteristics of an abscess anywhere in the body, in that cure is dependent on adequate drainage.

I am opposed to treating a lung abscess medically for one period of time and surgically for another. If the abscess is to be treated successfully, it should be treated during the acute phase by an integrated team. Within six weeks from onset, the optimum time for curative measures has passed and chronic pathological changes have already become established in the pulmonary parenchyma.

Once the patient with pulmonary abscess has come under your care, improvement must be prompt and progressive or the course of treatment should be radically changed. The improvement must be both clinical and roentgenological. No abscess is doing well which remains unchanged for two to three weeks at a time on the X-Ray film, even if there has been an amelioration of symptoms. Since all pulmonary abscesses communicate with bronchi, it is possible that internal or bronchial drainage will suffice. With this in mind, it becomes apparent that an appreciable percentage of abscesses may be cured by utilization of such drainage. This internal type of drainage is promoted by postural drainage and bronchoscopic aspiration. Poor postural drainage alone may produce more harm than good. Certainly an abscess in the upper lobe is not improved by postural drainage with

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the head placed in a dependent position. Many persons are acutely ill and cannot stand the physical exertion of routine postural drainage, and it must therefore be individualized.

The position which makes the patient cough the most and which utilizes the force of gravity should be assumed. This position, once decided on, should be used five to six times a day for a period of five minutes and should be personally demonstrated by the physician. At night, moderate Trendelenberg position will further increase gravitation of sputum to the trachea for evacuation and does not interfere with sleep. Another adjunct which complements postural drainage is the daily installation of endotracheal penicillin solution or other antibiotics. Their local application to a draining bronchus is efficacious. This procedure is carried out each morning before breakfast. It is easily accomplished by abolishing the gag reflex with a ½% pontocaine spray, and instilling 3 cc. of the penicillin solution (40,000 units per cc.). The patient is then postured so that the solution reaches the involved segmental bronchus.

It is obvious to those experienced in bronchoscopy that it is a valuable means of improving internal drainage. In the past, bronchoscopy has been used too infrequently during the acute stage. It should be one of the earliest therapeutic procedures employed. It has been stated that many of these patients are too ill to be subjected to bronchoscopy. It should be stated that they are too ill not to be bronchoscoped.

There are many who are not convinced of the value of bronchoscopy in pulmonary abscess. I am sure that such physicians have not had the benefit of an efficiently performed bronchoscopy or they have been swayed by the bronchoscopists enthusiasm and allowed repeated bronchoscopies to be performed without improvement in the patient's condition.

The bronchoscope is not an infallible instrument but it does have a rational use and will perform the following tasks: It helps establish a diagnosis by ruling out neoplasm or by finding an unsuspected foreign body. It will remove obstructing excretions from the main and secondary bronchi, and will shrink the congested edematous mucosa which in itself can cause obstruction. By the use of long curved aspirators, the smaller bronchi of the diseased pulmonary segment and on occasion, the abscess cavity itself can be drained. Direct instillation of antibiotics near the involved bronchial segment can be performed.

In favorable cases, the effect of bronchoscopy can be seen within a few days after the first aspiration. If doubt exists as to further improvement, a second or third bronchoscopy at three to five day intervals is indicated. If there is then still question it is unlikely that improvement has occurred and the treatment should be changed.

Evidence of clinical improvement is a decrease in cough, a reduction in sputum and fever, a change in odor and character of the sputum, and a feeling of well being. Should fever continue unabated and the secretions remain purulent and foul, it is certain that bronchoscopy is not effective.

Contra-indications for bronchoscopy are few. Brisk hemorrhage is a contra-indication, as is sudden chest pain with dyspnea, as this is evidence of rupture of the abscess into the pleural cavity. The former is an indication for surgical intervention; the latter, because of its overwhelming toxicity, resulting from insult to the pleura, needs rapid surgical evacuation—truly a surgical emergency.

If, within two to three weeks, and at most six weeks from the time of onset, there is no evidence of steady improvement, external surgical drainage should be undertaken.

If performed within this period of time, it is improbable that changes in the lung parenchyma and bronchial damage has occurred.

It has been demonstrated that most abscesses can be drained by a "one stage" technique, with a mortality rate of less than 4% in the acute stage. Since nearly all abscesses present on a pleural surface, adhesions rapidly form between

the lung and thoracic wall. Accurate roentgen localization is thus necessary. If after resection of one or two ribs, pleural symphysis is not observed, some type of irritating pack is used and the incision closed, to be opened two to seven days later when adhesions are suspected. At the time of open drainage, a biopsy specimen of the abscess wall is removed for pathological study. In certain cases, this may prove tuberculosis or other granulomatous disease, when all other tests are consistently negative.

The treatment of chronic pulmonary abscess presents a considerably different problem. External drainage is often unsuccessful because of secondary changes in the lung. If drainage has been established, often the cavity does not close and fistulae remain open.

A complete study of the lung therefore should comprise an adequate number of roentgen films taken in different positions and also should include fluoroscopy, bronchoscopic examination and bronchography.

If bronchial involvement is demonstrated, then some type of pulmonary resection is the treatment of choice. Lobectomy performed in the modern manner carries far less hazard than external drainage of a chronic abscess. In general, the more chronic the abscess, the less chance it has of being cured by external drainage.

What is meant by "chronic lung abscess"? This is an abscess which shows evidence of secondary changes in the bronchi or surrounding lung parenchyma as evidenced by fibrosis, atelectasis, bronchiectasis, stenosis, and often daughter abscesses, involving one or more lobes or even a whole lung and is entirely unrelated to the age or time of onset. Such an abscess, depending on its extent is best treated by primary segmental resection, lobectomy, or by pneumonectomy. Indications for resection other than the above mentioned complications of lung abscess is profuse hemorrhage, or when the diagnosis of malignancy is entertained. For obvious reasons, it is better to primarily resect abscesses in children. Abscesses which do not present themselves for external drainage, such as on the diaphragmatic surface, mediastinum or other inaccessible places, are again best treated by primary resection.

In summary, patients who do not improve progressively on a regimen consisting of postural drainage, bronchoscopy, and the antibiotics should be subjected to surgical drainage within a relatively short period of time (usually from 3 to 4 weeks). This means that ideally surgery will be performed in the acute or subacute stage. It must be kept in mind that holding ones own is not sufficient. A stationery course here is a retrogressive course. Chronic lung abscess is best treated by primary resection. I believe this will eventually replace open drainage in all forms of lung abscess except those where the disease is fulminating and drainage becomes a life saving procedure.

THE PHARMACEUTICAL ASPECTS OF PRESCRIPTION WRITING*

NOEL E. FOSS, PH.D.†

We of the Maryland Pharmaceutical Association are very pleased to have this opportunity to meet with the members of the Medical and Chirurgical Faculty of the State of Maryland. We are both members of the public health team which has for its primary purpose improving and maintaining the health of the public.

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† Dean of the University of Maryland School of Pharmacy.

Although there are many problems common to both of us which could be discussed today, I have chosen to discuss with you the pharmaceutical aspects of prescription writing.

A prescription is a written order of the physician for a remedy or medicine for a particular patient usually accompanied with directions for its administration to the patient. It is designed to procure for the patient a special remedy suited to his particular purpose and in such quantity as the physician deems needful.

Prescriptions should always be written carefully and legibly. Cases of damage suits against pharmacists have resulted from mistakes in deciphering what the physician had in mind. Usually the pharmacist calls the physician when there is any question as to the nature of the remedy or the directions, but this procedure consumes valuable time both for the pharmacist and the busy physician. Frequently a prescription that should be delivered immediately is delayed while the pharmacist locates the physician to clarify what was intended.

More recently the physician-pharmacist-patient relationship has been affected by the Durham-Humphrey amendment to the Federal Food, Drug and Cosmetic Act. This amendment, with which most of you are familiar, provides a statutory definition of certain types of drugs that may be sold by the pharmacist only on the written prescription of a "practitioner licensed by law to administer such drugs." It further provides that prescriptions for these drugs cannot be refilled except on the authorization of the prescribing physician. The prescription or refill authorization may be either written or oral (telephone). In the latter case the pharmacist is required to make a written record of the oral renewal and file it.

It must be further kept in mind that the definition in the law for prescription drugs includes drugs besides those that are directly dangerous. The three categories defined in the amendment are:

(1) Certain hypnotic or habit-forming drugs specifically named by the law, and their derivatives.

(2) A drug that is not safe for lay use "because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary for its use."

(3) A "new drug" that has not been shown to be safe for indiscriminate use.

Prescription drugs as defined above must be labelled by the distributor with the legend: "Caution: Federal law prohibits dispensing without prescription." If the label for a drug with this caution includes any directions for dosage or for use, it is designed primarily for the enlightenment of the pharmacist as well as the physician. On the other hand, any drug whose label includes the caution legend is a direct notice to the pharmacist, as well as the physician, that the product or preparation cannot be sold without a prescription.

Although there has been little difficulty insofar as original prescriptions are concerned, confusion has arisen over the requirement that refills must be authorized by the prescriber. A great deal of annoyance and misunderstanding can be avoided and compliance with the law facilitated if the physician at the time of writing or telephoning the original prescription would include instructions about refilling. The physician can authorize as many refills as he desires or he can authorize refilling for as long a time as his professional judgment indicates before he sees his patient again. Likewise, the physician can conserve his time by specifying that the prescription shall not be refilled. This informs the pharmacist that the physician wishes to see the patient before the prescription is refilled and hence saves much valuable time in phone calls for both the pharmacist and the physician. Most prescription blanks now include printed designations which permit the physician to indicate the number of times the prescription may be refilled, or that it should not be refilled.

It might be well to add a brief comment about the use of refill instructions such as "ad lib," "as requested," or "PRN." The Food and Drug Administration has investigated cases in which prescriptions for hypnotics, such as the bar-

biturates, or central nervous system stimulants, such as the amphetamines, were being refilled many years after they were written and which, in effect, permitted their use on a daily basis. It is quite obvious that the drugs in these cases were not being supplied in accordance with the will and purpose of the physician who wrote the original prescription. If the refill instruction is of an indefinite and continuing type referred to above, correction of abuses is complicated and difficult. It has been suggested that pharmacists should exercise their professional judgment and check with the physician when there is any indication that this refill privilege is being abused. I am sure you will agree that the alert physician will welcome such interest by the alert pharmacist.

On the other hand, it will be necessary for the pharmacist to check with the physician when a patient presents for refilling an old prescription which calls for a present day "legend drug." We trust that you will be tolerant in this matter of calls since it is the duty of the pharmacist to obtain the approval of the physician before refilling such a prescription.

We might emphasize that the pharmacist has a responsibility under the law to accept an order for a prescription drug only if it comes from "a practitioner licensed by law." We recognize as a practical matter that the physician's office nurse or secretary will, in many cases, telephone prescriptions or even authorize refills at your instructions, but it is the pharmacist's responsibility to make certain that the order is bona fide. Of course, nothing in the Food, Drug and Cosmetic Act in any way modifies the law and regulations relating to prescriptions for narcotics.

Although it is sometimes easier for the busy physician to tell the patient what to get, it is strongly recommended for two reasons that he write a prescription for the specific medication or remedy. First, the patient may confuse the name, especially in this age of euphonious trade names, or forget the name completely. Some years ago a patient requested Argyrol Solution when the doctor actually intended him to obtain Agarol. Second, the patient often consults the pharmacist to learn if the product that the doctor told him to obtain is suited to his needs without disclosing that the medication was recommended by a physician. On the other hand, a pharmacist considers a doctor's prescription as a private communication and always refers the patient to the doctor for any information relative to the action of the drug.

Closely allied to the verbal ordering of drugs for the patient is the practice of handing out samples indiscriminately. This is bad for the patient and bad for the doctor. It sends the patient down the road to self-medication, at the same time lessening the doctor's control of the patient. Frequently the patient passes the name of the item on to his friends; his friends do likewise; and in a surprisingly short time a new drug product becomes a household word.

With the passage of the Durham-Humphrey Amendment, there is another factor which enters into the practice of handing out samples if they are "legend drugs." Very often the patient takes the sample to his pharmacist and asks for another supply of this particular drug. When the pharmacist informs him that he cannot sell the drug without a physician's prescription, the patient immediately wants to know why. The pharmacist generally replies that it is a dangerous drug and immediately the patient becomes alarmed. It is, therefore, always good practice for the physician to write the prescription for the drug or drugs which he intends the patient to have.

One word about drugs intended for investigational use only. It is strongly recommended that the physician caution the patient using the drug that the drug can be obtained only from him or from the hospital with which he is associated and in no case will it be available from a pharmacist. Sometimes patients, probably unknowingly to the doctor, request preparations of this type from the pharmacist and the pharmacist spends considerable time attempting to locate the drug or preparation without realizing that it has not yet been released for prescription use. There are so many new preparations on the market

today it is almost impossible for the pharmacist to be aware of all the new ones that are released for prescription use.

In spite of the fact that the pharmacist is also a business man, I do wish to point out that because of his professional knowledge he has the right to expect the confidence and respect of his medical colleagues. He has been trained for four years in a college in one of the medical specialties. In addition, he has obtained the benefits of a one year apprenticeship or internship. He has been taught drugs from the chemical, physical, microscopic, pharmaceutical, pharmacognostic, physiological, pharmacological and bacteriological points of view. He has pursued a standard professional course to fit him for the job of preparing and dispensing medicine. He is the one member of the public health team who may claim to be an expert in pharmaceutical practice.

It is rather interesting to note that the Maryland College of Pharmacy, the predecessor of the University of Maryland School of Pharmacy, was organized in 1841 by a group of physicians and pharmacists. Three of the physicians, Doctors Samuel G. Baker, W. E. A. Aikin, and Wm. Riley, represented the Medical and Chirurgical Faculty. Although the course in the Maryland College of Pharmacy consisted only of lectures the first few years, it is interesting to note that from April 1844 the Maryland College of Pharmacy entered into an arrangement with the Faculty of Physic of the University of Maryland whereby the lectures of the college of pharmacy were united with those of the University so as to enable the students in medicine to have the benefits of the lectures on pharmacy in return for which the students of pharmacy were to enjoy the privilege of attending the lectures in chemistry by Professor W. E. A. Aikin, Dean of the Faculty of Physic. The lectures on pharmacy were to be delivered in the University building at Lombard and Green Streets, where quarters were placed at the disposal of the college of pharmacy. I mention this historical data to show the close relationship which has existed between the medical and pharmaceutical professions in the State of Maryland for one hundred and twelve years. Students in the School of Pharmacy at the University of Maryland are now again taking courses in physiology and biochemistry from these respective departments in the School of Medicine so that we once more have a close relationship.

We trust that the Maryland Pharmaceutical Association and the Medical and Chirurgical Faculty will work more closely together in the future to the benefit of both of these health professions. We need to cultivate a spirit of mutual understanding and cooperation if we are going to accomplish our best for the health of the public.

CURRENT VIEWS ON POLIOMYELITIS*

DAVID BODIAN, M.D.†

The floodlights of publicity not only have their proper function of revealing activity and progress in a field of public interest, but, as we all know, often produce the undesirable side-effects of magnification and distortion. The encouraging activities and progress in immunization against poliomyelitis are particularly vulnerable to these side-effects, because of the special incentive for wishful thinking which is associated with this disease, both in lay and in medical circles. It

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seemed to me, therefore, that it might be timely to present some of the current views on poliomyelitis which might serve as a background for your own evaluation of the status and prospects for passive and active immunization in poliomyelitis, and of the reservations to be kept in mind.

The progress which has been made in research on immunization has been accompanied by new findings in the field of pathogenesis of this disease. These have reoriented the thinking of many workers in regard to the nature of the infection. The advances have also, in a remarkable way, offered both increased hope for the development of an effective vaccine, and essential tools for this purpose. The finding that poliomyelitis virus can be grown in tissue cultures in the absence of nervous tissue has presented us with two important tools, the first being the means for producing large amounts of virus easily and cheaply. Second, it has made possible a superior method for measuring the concentration of virus in fluids from which vaccine is prepared, or the concentration of antibody in the serum of immunized individuals, whether experimental animals or human beings.

The tissue culture developments have also had the effect of reopening the question of whether the virus is confined only to nervous tissue in the infected person, or whether it also may multiply in non-nervous tissues, in which it may conceivably be more susceptible to neutralization by antibodies. As a matter of fact, evidence regarding the places in the body where virus multiplies is still incomplete. There is general agreement that virus first multiplies in the alimentary tract, and later invades the central nervous system. It is still not clear whether in its passage from the alimentary tract to the central nervous system, the virus may multiply in other structures, such as lymph nodes or spleen, or whether it passes along nerve fibers in an insulated fashion. There is now conclusive evidence, however, that virus is present in the blood serum in the pre-symptomatic period of the disease in human beings as well as in experimental animals. This, and other evidence, has suggested a very important possibility, namely that virus may invade the nervous system by way of the blood stream rather than by way of nerve fibers from the alimentary tract, as was previously believed by most of us. Although conclusive evidence for this view is not yet available, nor for the view that the virus is restricted to nervous tissue from its moment of

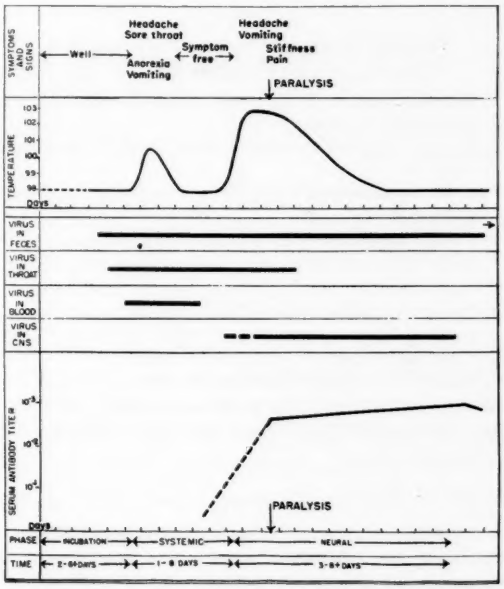

CHART 1

penetration into the infected individual, the implications for our understanding of the mechanisms of infection and of immunity are so important that much effort is being directed at obtaining a conclusive solution to this problem.

Chart 1 summarizes the evidence available regarding the time course of isolation of virus from important sites in the body, of development of serum antibody during an infection, and of occurrence of clinical signs and symptoms.‡ Of particular importance in current thinking is the

‡ More extended discussions of these points will be found in (1) and (2), which also contain more detailed bibliographic references.

fact that conclusive evidence indicates that the presence of specific serum antibody, before exposure, is an accurate indicator of immunity against paralytic infection. However, as shown in the Chart, in the natural paralytic disease serum antibody is already formed by the time of onset of CNS signs, presumably as a result of earlier virus multiplication outside the CNS. Despite this early antibody formation, the infection in the CNS may progress to produce severe paralysis or death. Three important conclusions emerge from these facts. First, in the natural paralytic infection the virus must localize in the nervous system before the formation of serum antibody reaches a high enough level to neutralize it. Second, by the time of onset of clearly recognizable symptoms of poliomyelitis it is too late to administer antibody in the form of gamma globulin or otherwise. The patient has already made more antibody than we can administer artifically. Third, prevention of paralysis by means of immunization should be possible if even low levels of serum antibody are produced, providing this is done before onset of typical symptoms and preferably before exposure. In other words, a small amount of antibody may be effective before exposure, but large amounts are ineffective after onset of CNS symptoms.

CHART 2

Limitations of Passive Prophylactic Immunization (Gamma Globulin)

1. Transient duration of any possible protection (few weeks).
2. Protection not certain.
3. Ignorance of optimal time of injection, because of ignorance of
   a. Who is susceptible
   b. Time of exposure
4. Limited supply and great expense of gamma globulin.
5. Large doses necessary, and repeated doses may hypersensitize.
6. Possibly inadequate potency, risk of reactions, and unknown risk of infectious hepatitis, in small and untested commercial lots prepared with new methods.
7. Danger of accidental intravenous injection.
8. Low incidence, even during epidemics, means that thousands may have to be injected to prevent a single paralytic case.

CHART 3

Problems of Active Prophylactic Immunization (Killed Virus Vaccine)

1. Duration and degree of protection against *paralytic infection* not yet tested in human beings.
2. Reactions in large scale use not known.
3. Only a few virus strains and inactivating agents tested thus far.
4. Methods for standardizing potency of batches of vaccine not developed.

The two major steps being explored are first, passive prophylactic immunization with gamma globulin, and second, active immunization with vaccines prepared from formalin-treated virus. Such so-called "killed" virus vaccines are rendered non-infective while still retaining antigenic potency for active immunization purposes.

Although there is limited evidence that passive immunization with gamma globulin may prevent paralytic cases under certain conditions, even Hammon and his colleagues,[3] who carried out the field trials, point out the severe limitations of this method. Chart 2 lists these drawbacks, which suggest that indiscriminate use of gamma globulin may not only be very wasteful, but may even be hazardous.

On the other hand, although the hope exists that vaccines will be developed before long which will not possess the limitations of gamma globulin, at the present time it should be clear that much work is needed to make possible the large-scale production of safe vaccines of standard potency, and to evaluate their efficacy in children over an adequate period of potential exposure. Chart 3 lists some of the problems which still remain to be solved. Nobody can as yet say how much more experimental work and how many small-scale human trials of new vaccines will have to be undertaken before we can be certain that all of the major problems are resolved.

There are a number of ways in which vaccines can be prepared, and many virus strains which are available for use in vaccines. It is important that time be allowed to develop a vaccine of almost absolute safety and proven potency before wide-spread use begins. In the meantime, it

is equally important to appreciate the limitations of gamma globulin as an immunizing agent, so as to minimize the wastefulness and even dangers of its irresponsible use. The practicing physician, who will be entrusted with the responsibility of administering the new immunizing materials, is in the best position to resist the abuses which may arise from the pressures of overly impatient or even hysterical parents.

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THE DIONE DRUGS IN PETIT MAL SEIZURES*

RUTH W. BALDWIN, M.D.†

This paper is being presented primarily to show, by means of electroencephalograms repeated at intervals, how some patients with petit mal seizures improve dramatically on treatment with the dione drugs, principally tridione. The presence of petit mal seizures is demonstrated in the electroencephalograms by the spike slow wave complex. Secondarily, the paper shows the importance of an electroencephalogram prior to treatment of any patient giving evidence of having epilepsy.

First a brief discussion of epilepsy of the petit mal or triad type as proposed by Lennox[1] is necessary in order that there might be a clearer understanding of petit mal. It cannot be emphasized too strongly that it is not a small or mild convulsion.

There are 4 kinds of epilepsy recognized today as shown in Figure 1. First, we see convulsions including Jacksonian March, focal, grand mal and tonic seizures. The last are usually seen in the young child only, and these change into the grand mal as the individual becomes older, if not controlled by medication in childhood. Secondly, we have the petit mal triad including petit mal absence or staring seizures which are brief lapses of consciousness, akinetic seizures or sudden loss of postural control, and the myoclonic jerk either single or massive which is a sudden, quick contraction of the muscles. Each of the patterns in this group will be discussed in more detail. Thirdly, there are the psychomotor or psychic equivalents—periods of amnesia. Last, we find the diencephalic or autonomic seizures which are paroxysmal disorders of the central nervous system.

Though the seizures of the petit mal triad are vastly different, they have many characteristics in common: namely, short duration, less than a minute; frequency, as many as 100 or more a day; sudden onset and termination; disappearance as patient reaches puberty; electroencephalographic similarity of spike slow wave complexes; improvement with same medication.

Petit mal absence or staring seizures are usually seen in the child of school age, where frequently the only complaint is from the teacher that the child pays no attention and daydreams. In these seizures the child stops his activity, stares straight ahead, turning his eyes to one side or the other or rolling them back with or without blinking of the lids. He may move his hands or feet in a rhythmic pattern with all

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† Director of Seizure Unit, Department of Pediatrics, University of Maryland School of Medicine, Baltimore, Md.

movements at the rate of about 3 per second. Occasionally there is incontinence of the bladder in the more severe of these seizures. They last only a few seconds, not more than 45, and may occur 100 or more times a day, with the child returning to his activity at the end of each usually not realizing he has had a seizure.

The akinetic seizures are characterized by a sudden loss of postural control, such as a sudden nod of the head or fall to the floor, collapsing in a heap. These are usually first noted by the mother when she is feeding the young infant in

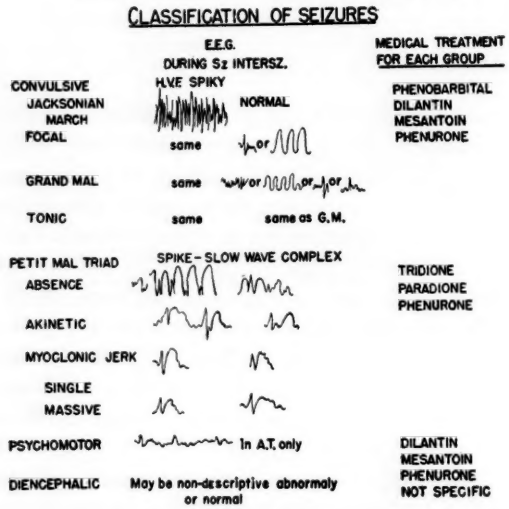


FIG. 1

the highchair and notices that his head falls forward frequently or when he is learning to walk and after a few steps crumbles to the floor in a heap straightening up in a few seconds. These may occur many times a day, and they frequently occur in bouts.

The single myoclonic jerk is a sudden jerk or a single contraction of the flexor muscles of the arm, leg or head. Anything held during one of these seizures of the arm is dropped or thrust away. The massive jerk is a sudden contraction of all the flexor muscles of the body, causing loss of posture. These are frequently mistaken for mild grand mal seizures, as the patient becomes momentarily stiff, may bite his tongue or injure himself; but no sleep or dazed period follows. Atypical seizures are seen at times, and included in this small group is a clinical grand mal case showing a spike slow wave in the electroencephalogram.

Many drugs such as phenobarbital, mebaral, dilantin, mesantoin, benzedrine, dexedrine, glutanic acid and caffeine have been used for these seizures, giving benefit to only a relatively few patients. Ketogenic diets and acidosis have also been of benefit to only a few. In 1944 a drug called tridione was first used experimentally by several investigators[1-6] and it was found to be

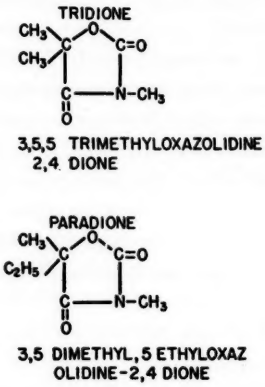


FIG. 2

very dramatic in its effect on petit mal seizures, but it seemed to accentuate grand mal seizures.

Tridione is a trimethyloxazolidine dione shown in Figure 2. Its analogue, paradione, dimethylethyloxazolidine dione, was produced because of the toxic reactions of tridione, the most severe of which is aplastic anemia.[7-12] Blood counts at monthly intervals on all patients taking either of these drugs have been found to be sufficient by Davis and Lennox[9] in a large series of cases. The fall in leukocytes was found to be very gradual. A slight increase in the lymphocytes and eosinophiles was also found with no change in the platelet count. Most fatal cases of aplastic anemia reported had not had monthly blood counts. Other toxic manifestations of these drugs

are rash, photophobia and drowsiness. The toxic reactions with paradione are usually less severe than with tridione, but its effectiveness has also been found to be less.[13] The dosage of both tridione and paradione is the same, starting with 1 capsule of 0.3 gm. a day in an infant and 3 capsules a day in a child of 6 years or over. They are both increased at monthly intervals by 1 capsule a day until all seizures are controlled or until toxic reactions occur. The top dosage for an infant would be 3 to 4 capsules daily; while in an adolescent child or older individual, it would be 12 to 14 capsules a day.

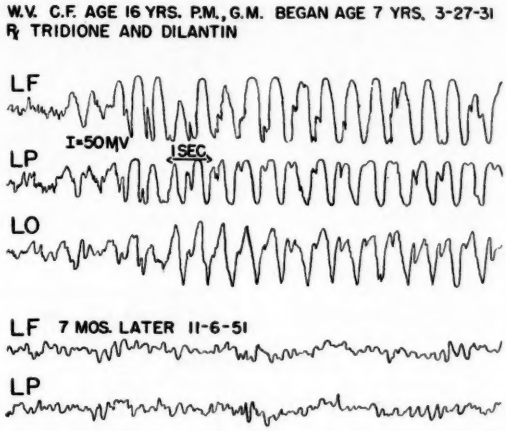


FIG. 3a

No attempt is being made to give a percentage of patients cured or improved with the dione drugs as used in the University Seizure Unit, in this paper. Brief mention can be made of Lennox[3] in his series of 166 patients having some form of petit mal. Of this series, 31% were free of petit mal seizures and 52% were improved, making a total of 83% who were greatly benefited by tridione. Most of these patients had had all other known forms of treatment with little effect.

Figure 3a shows W. V., a colored girl 17 years of age who had had grand mal convulsions since 7 years of age with petit mal staring seizures, 4 to 5 per day, for an unknown length of time as far as could be determined. The first electroencephalogram of 3/27/51 shows the typical spike slow wave complex with 3 such complexes per second and a number of clinical seizures during the record. The patient had previously been on bromides which were discontinued after 2 months and since 8 years of age had taken dilantin, 0.1 gm., three times a day and phenobarbital. At her first visit to the Seizure Unit she was put on tridione, 0.3 gm., three times a day; dilantin was continued and phenobarbital was gradually discontinued. The bottom section of this figure shows her record 6 months later,

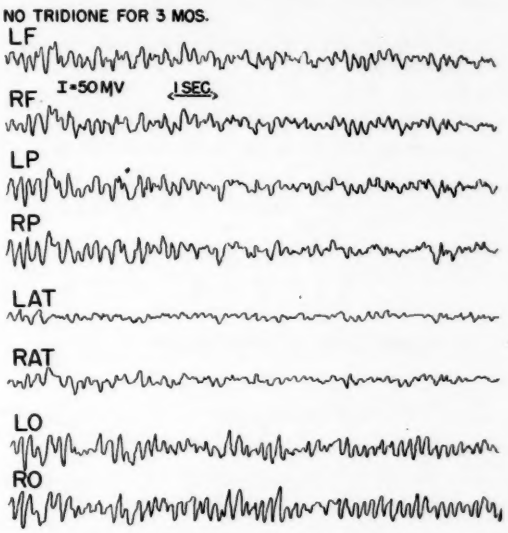


FIG. 3b. Six months later 5/6/52

11/6/51. Though it is still abnormal, the rate being too slow, there are no petit mal seizure discharges. Monthly blood counts remained within normal limits. From the first day of her new medication the patient had no further seizures, grand mal or petit mal. Figure 3b shows the record of 5/6/52, still abnormally slow; but there are no spike slow waves, though the patient has been off tridione for 3 months; and she has had no seizures of any kind. This patient has not been seen since this date, but recent information indicates she has had no seizures, and she is now taking no medication. Repeated attempts to have her return to Clinic have been unsuccessful.

Figure 4a shows B. M., a white girl of 15 years who had her first seizures of the tonic type as an infant. She was then free until 8 years of age, when she developed petit mal staring seizures; and at 10 years grand mal seizures began to occur. Previous treatments included phenobarbital, dexedrine, cold wave treatments, thiantoin and tridione. At the time of her first visit to the Seizure Unit, 3/14/51, her medication was thiantoin, 0.1 gm., four times a day and tridione, 0.3 gm., 8 capsules per day. The thiantoin was discontinued and dilantin, 0.1 gm., three times a day substituted and the tridione increased to 9

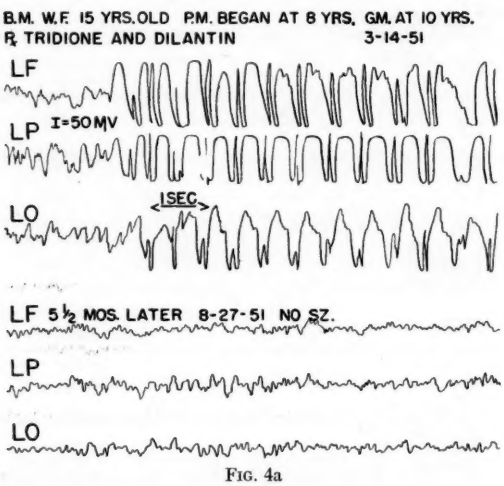


FIG. 4a

capsules a day. Her electroencephalogram at this time showed the 3 per second spike slow wave complex. From this date she had no grand mal seizures and her last petit mal seizure occurred on 3/23/51. The lower section of this figure giving the electroencephalogram of 8/27/51 shows that there are no petit mal seizure discharges, but the record is abnormal because of the slow and rapid activity. At this time gradual reduction of tridione by 1 capsule monthly was begun; and the electroencephalogram of 3/31/52, Figure 4b, still shows no petit mal seizure discharges. The lower section shows what her record looked like 1 year later, 3/16/53, after she had gone 1 year without tridione medication. The patient is seizure free at the present time. This case illustrates how only an increase of 1 more capsule per day was necessary for successful control.

Figure 5a shows M. D., a white girl of 17 years who developed her first grand mal seizure at 1 year of age and who since 1947 had been having 1 to 4 of these each year. A neighbor who was along with the family mentioned staring spells that she had noticed that were of no concern to the family. The first electroencephalogram of 2/8/51 showed a 3 per second spike slow wave

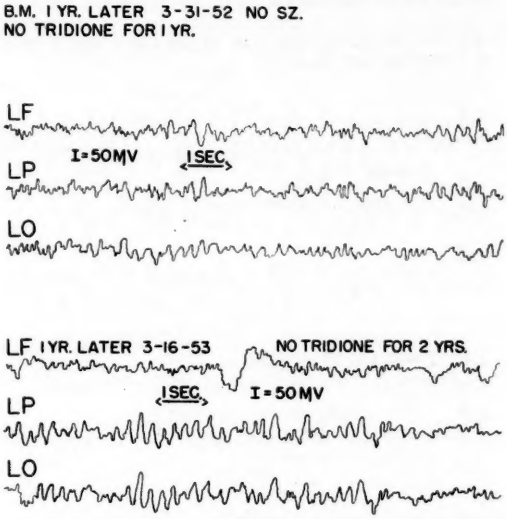


FIG. 4b

with several clinical seizures. Since the patient was on phenobarbital for the grand mal seizures, this was continued and tridione, 0.3 gm., three times a day was added for control of the petit mal seizures. However, because of photophobia, the patient reduced the tridione to once daily. Even with this low dosage there was only an occasional petit mal seizure, but the grand mal seizures continued to occur. On 8/28/51 the electroencephalogram of the lower section was obtained and only laval discharges of spike slow wave occurred. The tridione was increased to twice a day and instructions were sent to the family physician to increase the tridione each

month until all petit mal seizures were controlled and to have the patient wear dark glasses to counteract the photophobia. The record of 3/4/52 shown in the upper section of Figure 5b is free of all spike slow waves. At this time because of several grand mal seizures, dilantin was added to the medication and the tridione was discontinued. Here we note that the patient was free of petit mal seizures for 2 months only, and the record of 9/16/52 in the lower section of Figure 5b shows that the spike slow wave has

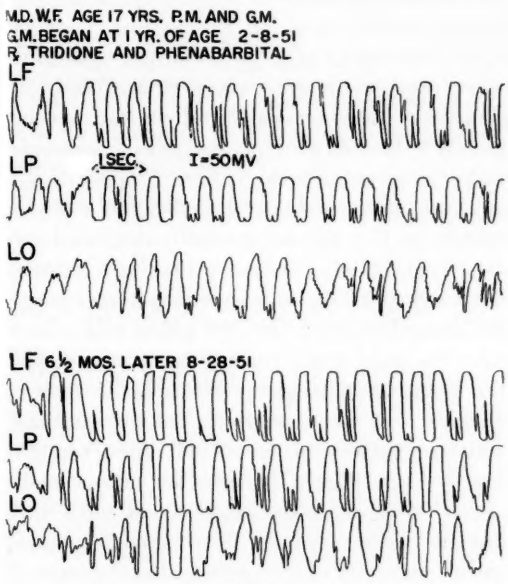


FIG. 5a

returned even though there had been no clinical petit mal seizures during this period of 2 months and no grand mal seizures. Tridione medication was restarted on this patient. The patient has since married and moved out of the state. She has had no further seizures and is expected to return within the next few months for another electroencephalogram. This case shows the inadvisability of discontinuing tridione until a patient has gone at least 6 months free of seizures, even though the electroencephalogram is free of spike slow wave complexes.

Figure 6 illustrates a case of myoclonic jerks in a white girl of 5 years. These occurred in bouts lasting 15 to 20 minutes each throughout a whole day about once each year in the spring with an

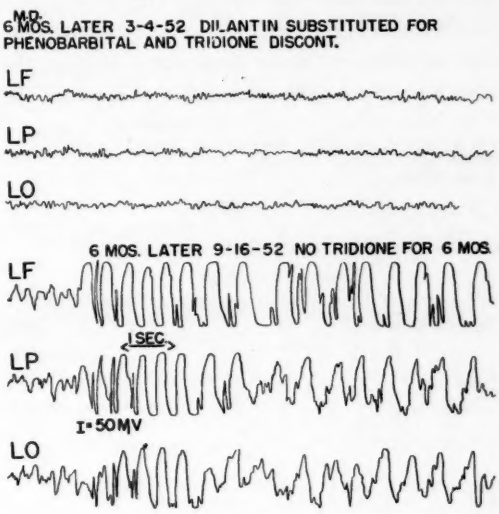


FIG. 5b

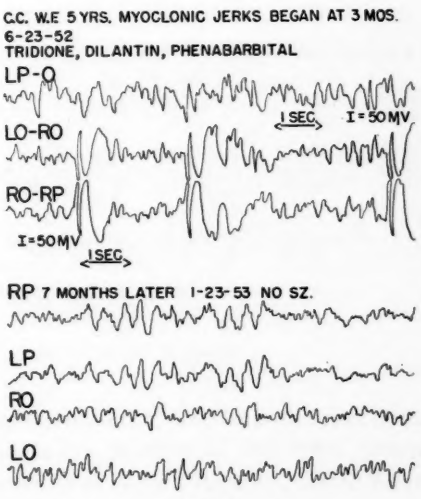


FIG. 6

infection. The child was a breech delivery following a rapid labor of 1½ hours. She was cyanotic at birth, put in oxygen and not expected to survive. The first electroencephalogram of 6/23/52 in the top section of the figure shows a

spike slow wave with a right occipital focus. The patient was put on tridione, 0.3 gm., three times a day along with the phenobarbital and dilantin she had been taking. The record of 7 months later in the lower section shows only some slow activity, no spike slow wave. During the month previous to the running of this record the

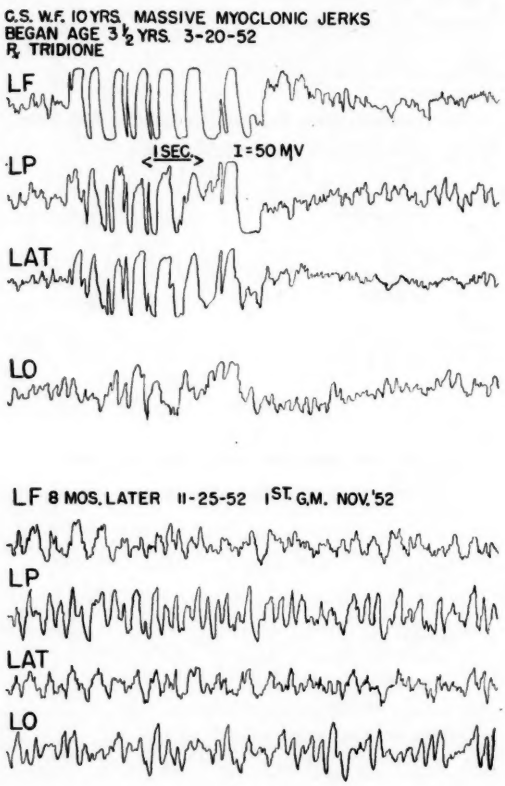
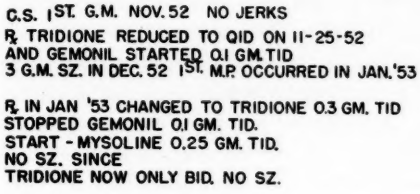


FIG. 7a

patient's polymorphonuclear cell count dropped to around 2,000 cells, so tridione was stopped. However, it was restarted 2 weeks later, because the count returned to normal. Since the repeat electroencephalogram showed loss of the spike slow wave, the tridione medication was reduced to twice a day. When the polymorphonuclear count dropped again the next month, tridione was discontinued. The count returned again immediately to normal, and the child has had no seizures this spring.

Figure 7a, C. S. is a white girl 10 years old who first starting having convulsions at 3½ years of age. These occurred every 3 to 4 weeks. She was put on phenobarbital and began having very frequent seizures in which the head and arms jerked. These occurred so frequently during a day that it was impossible to keep count of them. Ketogenic diet was tried as well as a phenobarbital derivative, dilantin, mesantoin and several experimental drugs. Her first electroencephalogram done at the Seizure Unit on 3/20/52 showed a spike or a multiple spike slow wave complex in the various areas, occurring sometimes simultaneously in all the leads accompanied by a clinical myoclonic jerk. The patient was started on tridione, 0.3 gm., three times a day, and the experimental medication was discontinued. Her seizures gradually decreased and after 4/21/52, when she started taking 5 capsules of tridione per day, there were no further seizures. In November, 1952, the first grand mal seizure since the child was 6 years of age occurred, and the electroencephalogram of 11/25/52 showed no spike slow wave complexes but slow and fast activity suggestive of a grand mal type of cerebral dysrhythmia. Figure 7b shows the various medications tried before the grand mal seizures were brought under control. First gemonil, a new barbiturate, was added to the reduced dosage of tridione. However, in January, 1953, with her first menstrual period she had 3 grand mal seizures; so the gemonil was gradually discontinued and mysoline, a new English barbiturate not yet on the market, was started in doses of 0.25 gm., three times a day. Since then there have been no seizures of either kind, and the last electroencephalogram of 4/7/53 shows slowing in the right occipital and low parietal areas, some of which appears to be a very immature spike slow wave complex. The next electroencephalogram will be important in indicating whether the spike slow wave has returned or not. So far there have been no petit mal seizures.

The last of the group of myoclonic jerks and grand mal seizures is Figure 8, C. P., a white girl of 2½ years who had her first convulsion with a high fever associated with pharyngitis. The patient was then free of seizures for 3 months and then began having myoclonic jerks, 15 or more a day; and 2 weeks prior to her first visit to the Seizure Unit was very much worse. Her first electroencephalogram of 10/30/52 showed a 2 to 4 per second spike slow wave complex as seen in the upper section of Figure 8. The patient



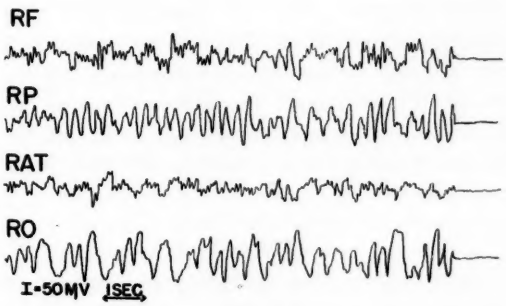


FIG. 7b

was put on tridione, 0.3 gm., daily. The following day she had a few seizures only and has had none since. Three weeks later this patient was admitted to University Hospital for a tonsillectomy and adenoidectomy, and a repeat electroencephalogram was obtained as shown in the lower section. Here we see a remarkable change in a period of three weeks only, the record now showing a poorly formed spike slow wave in the right anterior temporal area only. This case shows how rapidly the brain wave may begin to return to normal. Tridione medication, however, will not be stopped for at least 6 months and then only if the electroencephalogram is completely normal.

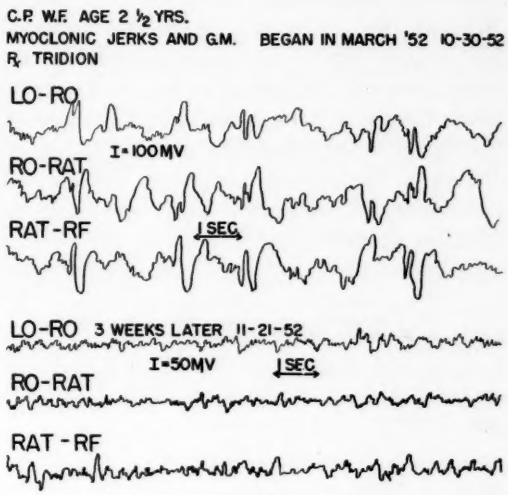


FIG. 8

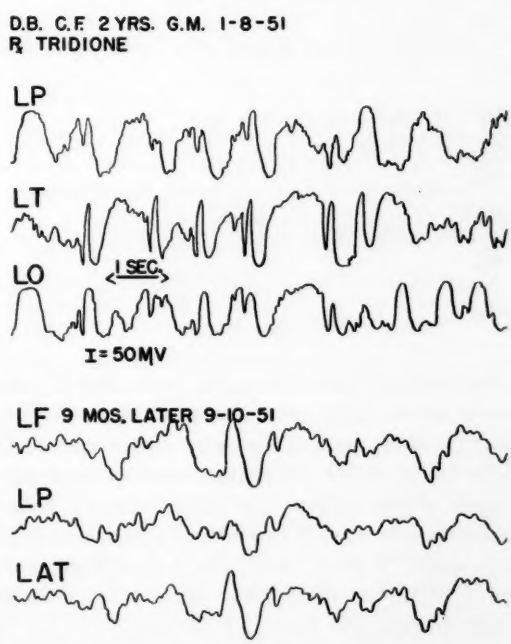


FIG. 9

Figure 9 shows D. B., a colored girl of 2 years, one of twins. At 3 months of age, she had pneu-

mococcal meningitis with repeated convulsions following. The child had to be readmitted to University Hospital on 2 occasions for convulsions. On the last admission she was comatose for 3 days. Her electroencephalogram at this time, shown in the upper section of Figure 9, shows the 2 to 2½ per second spike slow wave in the frontal areas bilaterally and at times in all the areas. The patient was put on tridione, 0.3 gm., daily. Her seizures stopped; she began to progress in development; and in the next 6 months she developed to a much greater degree

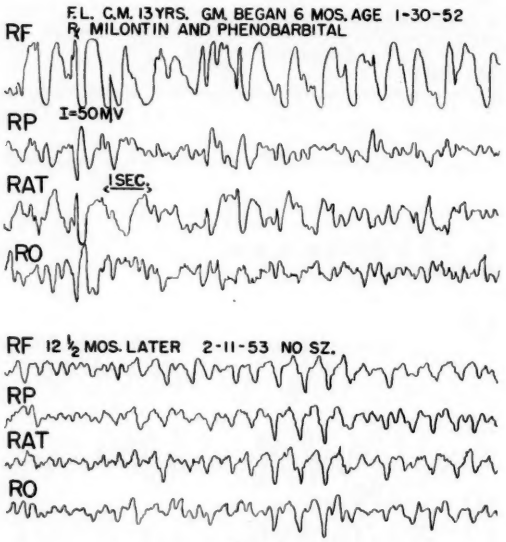


FIG. 10

than she had in her first 1½ years. She is still mentally back of her twin sister but she is able to talk, walk, memorize nursery rhymes and sing. The record of 9/10/51 in the lower section of the figure shows only a very poorly formed spike slow wave in the left frontal and anterior temporal areas. A more recent electroencephalogram of 2/19/53, not shown here, shows an occasional high voltage slow wave in these areas.

Figure 10 shows F. L. H., a colored boy 14 years old with a history of grand mal seizures having had his first electroencephalogram on 1/30/52. This record showed a 2 per second spike slow wave complex in the right frontal area and during deep breathing in all the areas. The patient was previously on phenobarbital and tridione was added to this. However, the polymorphonuclear count dropped to close to 1,500 cells; and tridione was discontinued. Paradione was started when the count returned to normal. Again the polymorphonuclears dropped, so the patient was put on milontin, a new experimental drug, N-methyl-α-phenylsuccinimide, on 8/28/52. The blood count has remained within normal limits on this drug. The electroencephalogram of 2/11/53 in the lower section shows no spike slow wave complexes. In this case it is difficult to determine which of the 3 medications, tridione, paradione or milontin, was responsible for the change in the electroencephalogram. Since there was a distance of over 100 miles for this boy to travel, it was not feasible to have electroencephalograms done on him between the changes in medication. This case was added last to emphasize the importance of electroencephalograms in the control of patients, because he clinically had grand mal seizures only, but his electroencephalographic record indicated petit mal seizures.

SUMMARY

Petit mal seizures including the staring or absence form, the akinetic and the myoclonic jerks both single and massive, all having spike slow waves in electroencephalograms responding dramatically in a number of cases to the dione drugs, tridione and paradione, have been discussed. The rapid change with loss of the spike slow wave complexes in a period of 3 weeks to 6 months has been shown in the case histories with repeat electroencephalograms. In the last case a spike slow wave was present in the tracing while clinically grand mal seizures only occurred, and with subsequent treatment with tridione, paradione and a new drug, milontin, the record became more normal.

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JUDGE RULES IN FAVOR OF ARMY IN NEW CONTEST OF DOCTOR-DRAFT LAW

The AMA Washington Letter, No. 36

In the first legal contest under the newly amended doctor draft law, a federal district court judge has ruled that the law passed by Congress last June does not make it mandatory for the armed services to commission a physician or dentist called up under the amendment. On a second issue of whether the Army must, therefore, give the doctor a discharge when he requests it, the question was not as clear cut. The judge held the petitioner (a 37-year-old dentist) had not contended he was inducted or being held in service unlawfully. The case, which is expected to be appealed, was heard in an Alexandria (Va.) court before Judge Albert V. Bryan.

The dentist, Dr. Herbert L. Nelson, was inducted May 28. On two occasions in filling out applications for commission he declined to state whether he had been a communist or a member of a communist organization. Subsequently, according to further testimony, he filed a statement admitting membership in the Young Communist League while in college and later in the International Workers Order. The Army informed the court that upon completion of basic training, Dr. Nelson would practice dentistry in the Army, probably at Fort Lee, Va., but that he wouldn't be commissioned nor allowed to handle any restricted or confidential material. Attorney for Dr. Nelson argued that if his client is to be retained on duty, then the Army is required to commission him in light of the new amendment. It states a physician or dentist "shall, under regulations prescribed by the President, be appointed, reappointed, or promoted to such grade or rank as may be commensurate with his professional education, experience, or ability." The court did not agree. The petition for a writ of habeas corpus was denied.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. John C. Devers has opened an office for the practice of medicine at 134 East Main Street, Frostburg, Maryland. Dr. Devers, a Navy veteran of World War II, is a graduate of Gettysburg College and the Medical School of Georgetown University. He served as an interne at Geisenger Hospital and Foss Clinic, Danville, Pa. While in the armed forces he served three years in the Navy Medical Corps.

Dr. James G. Stegmaier, 122 S. Centre St., Cumberland, has been made a Fellow in the American College of Surgeons. Dr. Stegmaier graduated from the University of Maryland Medical School in 1942 and served his internship at Mercy Hospital, Baltimore. As a commissioned officer in the U. S. Army, he was called to active duty in August, 1943 and upon discharge re-entered Mercy Hospital as Assistant Resident Surgeon in 1946 and Resident Surgeon from July, 1949 to June 1950, after which he entered practice in Cumberland.

Dr. George M. Simons has returned to Cumberland, after having served 6 months with the U. S. Army in Munich, Germany. Dr. Simons was in charge of the dispensary in the Munich Hospital and holds the rank of Captain in the Reserves.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

Robert Kimberly, Treasurer, reports that approximately seventy-seven per cent of the Baltimore City Medical Society members have paid the State Assessment of ten dollars. Probably more will pay now the summer is over. Paul Carliner and his special committee on the revision of the dues have done some effective work, and the appropriate action will probably have been taken in October at Bethesda, a month or two before this reaches print.

The Committee of Postgraduate Programs, under Harry M. Robinson, Jr., is developing a Fall program that will soon crystallize.

A closed TV program for November 5, from the University Hospital, may be sent as well to Wilmington if present plans work out. The Read Drug and Chemical Company is sponsoring the Baltimore part of the Clinics.

Baltimore City Society's new Constitution and By-Laws will be available for the December meeting.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.

Journal Representative

At the June meeting of the Baltimore County Medical Association, held at Pikesville's Ames Methodist Church, Dr. A. Bradley Daugharthy, of Halethorpe, presented to the members one of his lifelong patients, Miss Mary V. Hughes. Miss Hughes is the charming recipient of this year's nursing scholarship. She graduated in the top tenth of her class at Catonsville High School, and has chosen Johns Hopkins School of Nursing to continue her professional training. We shall follow her career with great interest. From the impression left with the Association, she should do well.

The members gave special recognition to Dr. George S. M. Kieffer on the event of his completion of the first 50 years of practice. Dr. Kieffer's calm, distinguished mien gives the lie to those who hold that the practice of Medicine is one not compatible with an unhurried and contemplative view of life, both as observed and as experienced.

At this same meeting we were privileged to hear Dr. Harry Porter expound most helpfully on the common diseases of the ear.

The following new members were voted into the Association: Dr. R. Donald Eney, Dr. Frederick E. Phillips, Dr. Timothy G. Williams, Dr. J. Jay Platt, Dr. Clarence E. McWilliams; Associate members: Dr. Samuel Whitehouse, and Dr. Arthur C. Tiemeyer.

CARROLL COUNTY MEDICAL SOCIETY

W. H. FOARD, M.D.
Journal Representative

The first fall meeting of the Carroll County Medical Society was held at Hoffman Inn, Westminster on September 16th with 22 present.

Our guest speaker was Dr. Robert Furie, Director of the Laboratory at Frederick Memorial Hospital and Medical Examiner of Frederick County. Dr. Furie reviewed the history of the Coroner and the Medical Examiner as we have it here in the State of Maryland. He gave us some very helpful information, so that we would be better able to determine the cases that should and the cases that do not fall in the province of the Medical Examiner.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

JOHN M. WARREN, M.D.
Journal Representative

For the past three months, this Society has been on summer adjournment so news has been kind of sparse.

The Prince George's County Medical Society held its Annual Golf Tourney on July 11. It was, as always, a great success, and quoting Dr. Warren, "I do not know when our members have a better time together than at these informal get-togethers."

At the September meeting, Dr. Welch, who is heading the Bureau of Medical Services for Maryland's Civil Defense Section which operates out of the State Department of Health, gave a brief outline of this State's efforts to date. He stressed that the State plan is predicated on the theory that no duplication will be made of existing facilities and that defense supplies will be useful for other purposes as well. With Dr. Welch leading the way, the Committee on Civil Defense of the Prince George's County Medical Society, headed by Dr. William Brainin, is to be vastly enlarged. Men from outside of the Society area—hospital superintendents, et cetera—will, no doubt, be called upon to serve so that the County will not be caught napping in reference to the medical service for Civil Defense.

Dr. Jack Sugar is spearheading the plans for a county-wide emergency medical call system. This is in the questionnaire stage and later reports will have more details regarding the System.

DR. KEEFER SWORN IN AS MEDICAL ASSISTANT, STARTED WORK SEPTEMBER 9

The AMA Washington Letter, No. 33

Dr. Chester S. Keefer of Brookline, Mass., was sworn in August 12 as Special Assistant (Health and Medical Affairs) to the Secretary of Health, Education, and Welfare in ceremonies attended by top officials of the department. Dr. Keefer explained that he has taken a temporary leave of absence as physician-in-chief at the Massachusetts Memorial Hospital and as Wade Professor of Medicine at Boston University School of Medicine. After a Canadian vacation, he will start work in Washington September 9. Dr. Keefer said he would devote as much time to the post as it required, but he indicated that once he became "set in the job," he would divide his attention between Washington and Boston. He does not plan to move his family to Washington. The day after the swearing-in ceremonies, Secretary Hobby entertained at luncheon for a group that included Dr. Keefer, Under Secretary Rockefeller, Surgeon General Scheele and four top officials of the AMA, President Edward J. McCormick, President-elect Walter B. Martin, Dr. Dwight H. Murray, chairman of the Board of Trustees, and Dr. F. J. L. Blasingame, chairman of the Board's Committee on Legislation.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

THE SELIGER COLLECTION

A fine collection of books on psychiatry and psychoanalysis from the library of the late Dr. Robert V. Seliger has recently been given to the Faculty Library through the courtesy of Mrs. Seliger. These books have greatly strengthened a weak spot in the library's holdings.

DROPSY

LOUIS KRAUSE, M.D.*

Dropsy has been known since ancient days, and was so called because it was recognized as an accumulation of fluid in the tissues, most frequently in the legs, this because of their dependency and gravity. Undoubtedly, it had been known since time immemorial.

Emphasis, of course, has always been placed on water restriction. This can be so readily observed in the ancient literature and even in modern literature. Recently, the emphasis has been shifted to the anchor that always fixes water in the tissues, namely Sodium. Now we see this condition responding more and more to treatment with the restriction of Sodium and the use of substances which displace Sodium. In these United States, we are using 10–20 times the amount of salt today than is required physiologically.

One could go on at length about the history of salt, but suffice it to say it was very difficult to obtain in the ancient days, used under very sacred conditions, and frequently paid out as wages. Interesting enough, our word *salary* comes from the fact that the Roman soldier was usually paid with a sack of salt instead of coins. This sack of salt was called *salarium*, hence our present term of *salary*.

To leave the seacoast anywhere except the United States, is to leave your source of salt. Wars have been fought over the presence of salt mines, and the course of history in portions of Europe has been changed as the result of the struggle for the possession of salt. The virtue of salt, being never indifferent and adding positivity to the medium in which it is, has been carried over into speech and human relationship, with such expressions as, "The salt of the earth" or "Let your speech be always with grace, but seasoned with salt" or the other expression used in arranging guests at a banquet table placing some "above the salt" and others below it.

Salt was used ceremoniously. Newborn babies were rubbed with salt (Ezek. 16:3). The Roman Catholic Church today still rubs the lips of the babies to be baptized with salt. The interpretation differs over the ages, and this custom goes back even before the days of Christianity and the Bible.

Today, we look upon salt as an electrolyte that should be maintained at a certain level in balance with other electrolytes. This is the bio-chemical approach to the control of dropsy.

The following list of books covers the story of dropsy from the past to the present:

Allston, W., An inaugural essay on dropsy, or the hydropic state of fever. Philadelphia, William W. Woodward, 1797.

Ayre, J., Pathological researches into the nature and treatment of dropsy. 2d ed. London, 1829.

Bacher, G. F., Recherches sur les maladies chroniques, particulièrement sur les hydropisies, et sur les moyens de les guérir. Paris, Thiboust, 1776.

Basham, W. R., On dropsy. London, 1858.

Blackall, J., Observations on the nature and cure of dropsies. 1st American ed., Philadelphia, James Webster, 1820. 2d ed., Philadelphia, 1825.

Chapman, N., Lectures on eruptive fevers. Philadelphia, Lea and Blanchard, 1844.

Christison, R., On granular degeneration of the kidnies. Edinburgh, 1839.

Fleming, G., Disputatio medica inauguralis, de hydrope ascite. Utrecht, F. Halma, 1689.

* Chairman, Library Committee.

Hamilton, W., De anasarca. Edinburgh, 1773.
Hart, H., De anasarca. Edinburgh, 1773.
Maclean, L., An inquiry into the nature, causes and cure of hydrothorax. 1st American ed., Hartford, 1814.
Monro, D., An essay on the dropsy and its different species. 2d ed., London, Wilson, 1756.
Monro, D., An essay on the dropsy, 3d ed., London, 1765.
Newman, R., Outline: pathological and practical views of hydropic diseases. Winchester, Davis, 1822.
Newnan, J., An inaugural dissertation on general dropsy. Philadelphia, Parry Hall, 1793.
Osborne, J., Nature and treatment of dropsical diseases. London, 1837.
Piaggio Blanco, R. A., Las ascitis, por los doctores Raul A. Piaggio Blanco, Carlos Sayagues Laso, y Federico Garcia Capurro. Barcelona, Salvat, 1944.
Sermon, W., A friend to the sick: or, the honest Englishmans preservation. London, Edward Thomas, 1673.
Seymour, E. J., Nature and treatment of dropsy. London, Longman, 1837.
Spooner, W., Dissertatio medica inauguralis de ascite abdominali. Edinburgh, 1785.
Todd, R. B., Clinical lectures on certain diseases of the urinary organs. Philadelphia, 1857.
Whytt, R., Observations on the dropsy in the brain. Edinburgh, 1768.
Withering, W., An account of the foxglove, and some of its medical uses. Remarks on dropsy, etc., Birmingham, G. G. J. and J. Robinson, London, 1785.

PHS DETERMINING COST OF FREE MEDICAL CARE FOR U. S. PERSONNEL

The AMA Washington Letter, No. 38

As an outgrowth of a budget dispute over the free care of merchant seamen in Public Health Service hospitals, a study is being made to determine what it costs PHS each year to care for patients turned over to it by other government departments. The issue arose after the Budget Bureau told the Department of Health, Education, and Welfare to prepare its next budget excluding the care of merchant seamen, which has been considered a federal responsibility for about 150 years.

Secretary Hobby informed the Bureau she would comply, but that she would also have to determine the costs to PHS of caring for thousands of other patients for whom the federal government has assumed responsibility. She added that the review will consider, among other things, whether her department should not be reimbursed by the other federal departments for this hospital care.

Mrs. Hobby noted that the Treasury Department's Coast Guard personnel also are treated free in PHS marine hospitals, as are employee compensation cases of all departments under a program handled by the Labor Department. Because merchant seamen make up about 40 percent of all cases in the 16 marine hospitals, PHS plans to close up all these hospitals if it is denied funds to care for the sailors. This would require the government to make other arrangements for the care of hospital and dispensary patients from other government departments, who average about 10,000 per day. Where the seamen would receive care probably would be determined by the unions and the shipping lines.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Baltimore's Decline In Tuberculosis Mortality

A recent analysis of the vital statistics for the first half of 1953 indicates that a substantial decline in tuberculosis mortality has been recorded when compared with the experience of the first six months of 1952. For the period January–June of the present year, 150 deaths were ascribed to tuberculosis of all forms. The number recorded for the equivalent period last year was 240. This drop of 38 per cent constitutes one of the most dramatic advances which we have made in Baltimore in the fight to control tuberculosis. It is not possible to state exactly which factors are associated with this marked decline. However, studies presently in progress, give indication that the program of treating patients with streptomycin at home, while they await hospitalization, may be a significant element in preventing rapid and early death among acutely ill tuberculosis cases. The relatively high standard of living enjoyed by a wide proportion of the population and the increasing availability of beds and effectiveness of care in tuberculosis hospitals are additional factors which may account for the sharp decline in tuberculosis mortality. If the tuberculosis mortality experience for the first six months of 1953 continues during the last six months, it is estimated that the death rate for this disease will be 19 for 100,000 population for the white segment of the population and 70 for the colored population as compared with rates of 24.0 and 104.1 which were recorded in 1952.

Huntington Williams, M.D.

Commissioner of Health

ARMY TURNING OVER 450 PHYSICIANS TO NAVY, AIR FORCE

The AMA Washington Letter, No. 37

The Army, which had a physician-troop ratio of 3.61 on September 1, has begun redistribution of 450 newly commissioned physicians to the Navy (3.69 ratio) and Air Force (3.10 ratio). If these medical officers don't ask for interservice transfer, "then it may be necessary to detail some of them," Defense officials state. Overall ratio for the armed services September 1 was 3.49, according to the department. Last January the Health Resources Advisory Committee recommended the doctor ratio be reduced to 3.0, and in May Secretary of Defense Wilson directed that this ratio be reached by June 30, 1954. As late as June of this year, however, the ratio was 3.45. Since July 1 the department has stopped counting interns and counts only half of its residents in arriving at the doctor ratio. Previously, both groups were counted in full. On September 1, services listed 555 interns, 769 residents.

The redistribution program was announced simultaneously with disclosure that the military was halting drafting of physicians for an indefinite period. The department explained that it had so many volunteers after extension of the doctor draft and issuance of August call for 542 physicians, it did not have to resort to the draft. The department also said many doctors entitled to release under the new law are staying on, and that there are fewer deferments for professional training.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 2-29, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	7	—	—	1	—	—	9	14	4	—	2	—	—	1	9	—	13	—	6
Anne Arundel	1	—	2	—	1	—	3	3	2	—	—	1	—	1	1	4	5	—	1
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	1	—	—
Harford	2	—	—	2	—	3	1	2	—	—	—	—	—	—	2	—	—	m-1	—
Carroll	—	—	—	1	—	—	—	1	—	—	—	—	—	—	2	—	—	—	1
Frederick	—	—	—	1	—	—	—	1	—	—	1	—	—	—	—	—	3	—	1
Washington	—	—	1	—	—	—	—	—	—	—	1	—	—	—	5	—	1	—	1
Allegany	—	—	—	3	—	—	—	1	—	—	1	—	—	4	3	—	—	—	2
Garrett	2	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery	4	—	—	1	4	—	5	8	3	1	5	—	—	—	6	—	3	—	—
Prince George's	—	—	—	4	—	—	1	4	1	—	3	—	1	—	12	—	4	c-1	—
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles	—	—	1	—	2	—	—	—	—	—	—	—	—	—	5	—	—	—	—
Saint Mary's	—	1	2	2	—	—	—	—	—	—	1	1	—	—	—	—	1	—	—
Cecil	1	—	—	1	—	—	—	—	1	—	1	—	—	—	1	—	2	—	—
Kent	—	—	—	4	—	—	4	1	1	—	—	—	—	1	1	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	4	2	—	1	—	—	—	2	—	—	—	1
Caroline	1	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	2	—	—
Talbot	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	—
Dorchester	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	9	—	—
Wicomico	1	—	1	—	19	—	2	—	—	—	—	—	—	—	3	—	11	—	—
Worcester	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	1	—	—
Total Counties	21	1	7	24	26	3	26	40	14	1	17	2	1	9	56	4	57		13
Baltimore City	27	0	6	9	35	3	52	14	8	0	17	3	0	31	96	16	566	a-1	18
State																			
Oct. 2-29, 1953	48	1	13	33	61	6	78	54	22	1	34	5	1	40	152	20	623		31
Same period 1952	22	1	7	16	18	5	25	59	56	0	43	4	1	7	174	15	627		34
5-year median	34	4	4	—	23	1	23	38		2	38	4	2	60	189	57	662		33
Cumulative totals																			
State																			
Year 1953 to date	2750	11	1439	430	1554	66	2324	287	203	24	2224	29	10	336	1957	132	6779		605
Same period 1952	2759	8	840	198	9088	76	940	163	133	28	880	19	14	172	2247	164	6210		542
5-year median	3077	63	530	—	4013	61	1613	194		56	923	30	36	684	2302	724	6347		511

a = amoebic dysentery.
c = congenital syphilis under 1 year of age.
m = malaria contracted outside of Maryland.

Blue Cross - Blue Shield

ENROLLMENT REGULATIONS FOR BLUE SHIELD

R. H. DABNEY*

A recent survey of Blue Shield participating physicians in a large nearby State revealed that the Plan's enrollment regulations and procedures were subjects involving the most questions, comments, and complaints. While the doctors' interest in the problem clearly indicated that they wanted Blue Shield to grow—and grow faster than it had—it also revealed some misunderstanding of why it is necessary to set certain controls on the enrollment of subscribers.

Basically, enrollment regulations are a means of underwriting business to obtain an average selection of risk, which in turn will assure sound financial operations and the maintenance of a modest subscription charge. These regulations take two principal forms: first, the insistence on a percentage of participation in employed groups—50% of employees in groups over 200, 60% in groups of 30 to 200, and so on to 100% for small groups of five persons; and second, the establishment of specific times, usually twice a year, when additional applications are accepted. Actually, in comparison with other Blue Shield Plans and programs offered by commercial carriers, our requirements in Maryland are not severe.

No one can deny that these regulations, unfortunately, make it impossible for some worthy persons to join up. On the other hand, it is obvious that without percentage requirements the chronically ill would sign up first and would soon outnumber the healthy ones, leaving the Plan with an adverse overall risk. If Blue Shield is to fulfill its purpose as a community program to assist those in modest circumstances to finance the costs of hospitalized illness, and is to maintain its modest subscription rates, then it must continue to enroll a goodly number of healthy people to balance the numbers who are going to need medical care. Groups with low utilization must be enrolled to balance the groups with high utilization.

To date, Blue Shield, like Blue Cross, enrolls new members only through groups. We hope at some future date to be able to offer non-group enrollment for the self-employed and for those who work where there are less than five employees. Such a program will necessarily require underwriting of individual risks, which, in turn, will add to the cost for the subscriber.

The future success of Blue Shield, we believe, lies not in accepting members indiscriminately, but in convincing the people that Blue Shield—the doctors' program—is the best there is; that through membership in this non-profit Plan they will receive comprehensive protection, the maximum return in benefits for their subscription dollar, and the best in medical care.

* Executive Director, Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

THE DOCTOR IS THE KEY TO THIS BLUE CROSS PROBLEM*

THE SUN, BALTIMORE, MARYLAND, SEPTEMBER 11, 1953

Speaking before the American Hospital Association in San Francisco, Dr. John W. Cline, former president of the American Hospital Association, warned that overuse of hospitals by subscribers to the Blue Cross is burdening the prepaid medical-care programs and reducing their efficiency. Dr. Cline stated that some patients insist on the top limit of the service on the ground that they have paid for it and are entitled to it.

Inquiry reveals that the problem exists here in Maryland. The incidence of going to the hospital in relation to the total membership in Blue Cross is rising. However, the rate in Maryland is lower than the national average and always has been.

The incidence rate, of course, plays a vital part in determining the cost of insurance to each member. The more the hospitals are used, the greater the cost to them. If hospitals are used more than is necessary the result may be a raising of the insurance rates or reduction of the services offered.

One possible solution of the problem would be to include a deterrent in the contract, such as requiring an initial payment by the patient. Another would be to follow the practice of the commercial companies and exclude those individuals regarded as poor risks. But that plan would destroy the main purpose of Blue Cross, which is to insure as many persons as possible.

The more the problem is studied the more evident it becomes that the doctor is the key man. No patient can be entered in a hospital under Blue Cross without his indorsement. He knows whether hospitalization is really necessary. Where it is not, it is up to him to acquaint the patient with the importance of keeping the incidence rate low for his own sake, for the sake of the profession and for the medical-care program as a whole. This is a matter in which patient, doctor, hospital and Blue Cross all have a stake.

* Appreciation is extended to The Sun for permission to reprint this article.

VA HOSPITALIZING MORE NON-SERVICE CONNECTED CASES

The AMA Washington Letter, No. 40

Latest statistics from Veterans Administration show the agency is reducing its lists of service and non-service connected cases awaiting hospitalization. In August 1952 service-connected cases waiting admission totaled 143. During July and August of this year they numbered only two. At the same time VA is getting more and more non-service connected cases into its hospitals. In August 1952 VA listed as waiting hospitalization 22,341 cases it described as "other than disabilities adjudicated service-connected." By July of this year only 20,370 were still waiting treatment, and in August only 17,874.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

HOW TO WORK WITH WOMEN'S CLUBS*

MRS. SHELLEY DAVIS

Woman's Auxiliary, Medical Association of Georgia

With continuing wars depleting the ranks of our nation's manhood, more and more women are rising to positions of importance in business, industry and politics. No longer does madam concern herself merely with sewing a fine seam. Today she must consider the bank account, taxes, economic trends, and finally, protecting her health and that of her family.

Focus on Women

From time immemorial, women have been reminded that they know nothing of world affairs, and so today, women's clubs bring women a form of packaged-learning. In one hour's time, hundreds of women can learn enough from a well-prepared speaker to set them thinking for months.

Intelligent women's groups carefully plan diversified programs well in advance. The General Federation of Women's Clubs, which boasts a membership of well over eleven million women, is the largest group of organized women in the world. Yet it has direct contact with the smallest women's club in the most rural community. What a terrific potential for programming!

Now, just suppose that Mrs. Oscar Ahlgren, president of the General Federation of Women's Clubs, urged her state and district presidents to plan one local health meeting during the year. Then suppose the health and welfare chairmen of the local clubs, plan a meeting and invite the local county medical society to present a program on voluntary medical care insurance or labor costs in medicine—any number of subjects with local application. This could be a medical public relations school!

I wonder what the average doctor-speaker would do if his typewritten paper were suddenly snatched away from him? Perhaps he would no longer be guilty of muttering in his beard. Perhaps he would convey a feeling of sincerity and human interest by looking at his audience instead of a sheet of medical statistics.

Now, in every community, the League of Women Voters is busily preparing information on current legislation. How much easier the job would be if the local county medical society's committee on legislation would invite representatives from the League of Women Voters and explain the ramifications of proposed health and medical legislation.

Another great source of power today lies in such women's service organizations as the Pilot Club, the Business and Professional Women's Clubs, the Quota Club, the Women's Chamber of Commerce, the Women Lawyers Associations and so forth.

Theirs is a very busy schedule, but they fill a definite niche in the community. How much closer medicine could work with these groups if local and state medical society officers invited these club members to an informal get-together and offered vital, current woman-interest material for monthly release.

Even though many physicians shun publicity, extra work and the criticism of constituents for taking leadership, service on a community health council is a golden opportunity for doctors to regain deserved community respect.

Perhaps one of the most unexplored potentials for good public relations in women's organizations is the use of the thousands of women physicians. There is a unique tie-in with wives and mothers. And, at the same time, representation of the American Medical Association. Surely, with little public

* "Putting PR to Work—A Digest of Proceedings of the First Medical Public Relations Institute, September 4 and 5, 1952, Chicago, Illinois." Reprinted by courtesy of American Medical Association.

relations briefing, their entries would be legion. Why not utilize this wealth of ability already within the ranks of medicine?

Other organizations such as the American Association of University Women include in their yearly programs some phase of education. Rarely does a program chairman pass up a good movie short. Here lies another opportunity to tell medicine's story.

And last, but by no means least, is the Woman's Auxiliary. Every doctor's wife, whether she wants to be or not, is a spokesman and a public relations agent for the medical profession. She no sooner walks into a PTA meeting or the country club than she is asked what doctors think of the cobalt bomb or polio immunization. Her name is read as chairman of health committees without her consent. If she pleads home duties, she is guilty of shirking community responsibility. Since she learns this is part of her life, why not make it good.

In the Auxiliary she finds solace with other doctor's wives who must play second fiddle and share their husbands with just everybody. But she also finds how utterly interesting it is to work in civic activities. And so, understanding cements family unity and creates a vital, energetic medical auxiliary.

Where there is no medical auxiliary, the doctors say won't you girls get together and help us out? Since the Divine Maker created Eve, women have played a part in shaping the pattern of destiny. With just a little honest persuasion, they can be invaluable aids in shaping the destiny of American medicine.

COMPONENT NEWS

I am sure you will be pleased to learn of the release of Dr. Alexander M. Boysen from a Korean prison camp. Dr. Boysen was captured in 1950, and is the son-in-law of Dr. and Mrs. Gerald Le Van, Boonesboro, Maryland.

Mrs. LeVan is the President of the Woman's Auxiliary to Washington County.

CAPS AND BELLES

Mrs. E. Roderick Shipley, Program Chairman, and Mrs. Conrad Acton, Corresponding Secretary of the Woman's Auxiliary to the Baltimore City Medical Society, report a premiere showing of the film sponsored by the "Nurse Recruitment Committee," on Wednesday, December 2, 1953, at 11:00 a.m., at 1211 Cathedral Street.

This film contains scenes from most of the hospitals in Baltimore and many of the surrounding territories.

INCREASED MEMBERSHIP

Mrs. Thomas E. Wheeler, President of the Woman's Auxiliary to the Baltimore County Medical Association, has just presented Dr. Wheeler and the Auxiliary with a new member—Melannie Lorraine, weight 8 pounds.

WASHINGTON COUNTY AUXILIARY STARTS PUBLICATION

The Woman's Auxiliary to the Washington County Medical Society has started to issue a bulletin four times a year to all members. The first issue brought news that the Western Maryland Chapter of the Maryland Motor Truck Association, Inc. had presented to the Auxiliary a citation for meritorious service for their "unselfish devotion of time and energy to the interest of safety in Hagerstown and Washington County." This certainly shows great work and talent and wonderful Public Relations for our Auxiliary.

TIPS 'N TOPICS ABOUT TODAY'S HEALTH

Reprinted from July, 1953, issue Woman's Auxiliary to the American Medical Association

—"SACK OF CANDY" IDEA IS SUCCESSFUL HERE—

Eight of the obstetricians of Dade County, Florida, cooperated last year in a program of getting TODAY'S HEALTH into the hands of young parents. As the bill for the baby was paid in full, a gift subscription was sent to the mother and father of the baby as a thank-you (sack of candy) from the obstetrician. All the doctors who participated in this scheme say that their patients were most grateful and have mentioned the gift more than once.

The important thing about this program is that it doesn't stop with the one-year gift subscription from the obstetrician, but the parents are potential customers for the Dade County Auxiliary, and as the subscriptions come due this year, the auxiliary will approach this group for renewals.

Ancillary News

PHARMACY SECTION

LET'S BRING IT OUT IN THE OPEN

L. M. KANTNER, PHAR. D.[1]

In recent months there has been widespread use of the term "Substitution" applied to prescription practice. Pharmacists are being accused, and unquestionably correctly, of using on prescriptions a product other than that which was specified. The accusation emanates largely from pharmaceutical manufacturers, who charge the offense ranges from substituting one brand for another to the use of out and out counterfeit preparations.

Without fear of contradiction, I believe this offense is practiced by a small minority of pharmacists, but even that number is too large. Pharmacists, who have no part in such acts, are strong in their condemnation of these practices and are active in exposing and penalizing the participants. Economically, it is a type of competition that cannot be competed with by ethical pharmacists.

At the outset, let it be crystal clear that the writer does not condone even the odor of substitution when it is applied to dispensing medicines except in emergencies, and these are so rare as to be dismissed from further comment.

Although there may be some points raised here that can be claimed as contributing factors leading to substitution, they should not be construed as defending the practice in any way as will be pointed out later.

So far as pharmaceutical manufacturers complaining about substitution, this deals primarily with the economics involved. The drug industry operates in free and open competition, as it should, and in this respect does not differ from other industries.

Because of this freedom, manufacturers duplicate their competitors' preparations with impunity. With the result that there are numerous preparations on the market that are identical so far as active ingredients are concerned, and the difference of one product from another is largely that of color or flavor.

From a realistic standpoint, there could be no criminal offense in the interchanging of such preparations. However, as the prescriber is the figure in command, the pharmacist has no alternative than to explicitly carry out his order without the prescriber's authorization to do so. In this respect, the average physician is approachable to permit the use of an identical brand to the one prescribed, provided assurance is given that the brand suggested is a product of as reliable a manufacturer as the one whose product was specified.

As to duplications, it is interesting to note what a former vice-president of one of the leading pharmaceutical houses has to say, and I quote:

"Pharmaceutical manufacturers must take the initiative in ending the economic waste and dilution of effort in marketing that results in duplication of products."

He further stated that the original work on isoniazid was done by two or three companies, and by the time the product was ready to put on the market there were thirty-eight or so brands.

Now, it stands to reason that no pharmacy could be expected to carry thirty-eight brands of an identical preparation. However, manufacturers give their products a trade or brand name notwithstanding the products are identical.

Another example concerns the antibiotic, erythromycin, a discovery that restricts its manufacture to three companies. Two of the manufacturers elected to identify their product with a brand name, while the third was satisfied to use the generic name. Although all are identical, each manufacturer coats the tablets a different color as a mark for identity. If a pharmacist carries two of the brands in stock and receives a prescription for the third manufacturer's tablet, which he does not have, one of the

[1] Secretary, Maryland Board of Pharmacy.

other two brands cannot be used unless the prescriber authorizes the change. Does it or does it not make sense?

Up to this point, the only type of manufacturers that have been considered are those of the highest order whose reputation is reflected in their products.

Unfortunately, there has developed a type of manufacturer who relies on counterfeiting. This type develops nothing worthy of consideration. His survival depends on imitating other products and having them used for substitution purposes. Some of these manufacturers have become so bold as to catalogue their products, and in juxtaposition the preparations they can be substituted for are listed.

As stated before, only a small number of pharmacists are guilty of substitution. This is not a glib remark. There are records to substantiate it. Manufacturers are spending large sums of money for investigations, and the records show that substitutors are greatly in the minority. The pharmacists who do substitute, for reasons quite understandable, have little opportunity to do so because their prescription business is meager.

There are about 50,000 pharmacies scattered over the United States, and if 20 per cent practiced substitution, their purchases would be insufficient to support counterfeiting manufacturers.

The question arises: Where do these counterfeit products find a market sufficient to support operation? There is every reason to believe it is not in retail pharmacy.

SECTIONAL MEETING OF THE AMERICAN COLLEGE OF SURGEONS

February 1 to 3, 1954

Hotel Charlotte, Charlotte, North Carolina

Preliminary details of the program give promise to a very interesting meeting.
For additional information, contact Dr. E. Roderick Shipley, Medical Arts Building, Baltimore 1, Maryland.

JOINT ANESTHESIA STUDY GROUP

Otto C. Phillips, M.D., *Chairman*

Wednesday, December 16, 1953, 8:30 p.m.

Guest discussants. Dr. Otto C. Brantigan, Associate Professor of Surgery, University of Maryland School of Medicine, and Dr. James Maloney, Assistant in Surgery, The Johns Hopkins Hospital.

Coming Meetings

CANCER SECTION

Arthur G. Siwinski, M.D., *Secretary* — Edwin H. Stewart, Jr., M.D., *Chairman*

Wednesday, December 9, 1953

Dinner Meeting

U. S. Public Health Service Hospital

Time and Program to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

Richard W. TeLinde, M.D., *Chairman* — Beverley C. Compton, M.D., *Secretary*

Thursday, December 17, 1953, 5:00 to 6:00 p.m.

1211 Cathedral Street, Lower Floor

MATERNAL MORTALITY COMMITTEE

Thursday, December 17, 1953, 4:00 p.m., Osler Hall

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

BALTIMORE CITY MEDICAL SOCIETY

WETHERBEE FORT, M.D., *President* — EDWARD F. COTTER, M.D., *Secretary*

LEWIS P. GUNDRY, M.D., *Vice-President* — ROBERT C. KIMBERLY, M.D., *Treasurer*

ANNUAL MEETING

Friday, December 18, 1953, 8:30 p.m.

Reports of Committees and Election of Officers

SYMPOSIUM ON TUBERCULOSIS

ROSS L. MCLEAN, M.D., *Moderator*

Participants:

Colonel Carl W. Tempel, MC., Chief, Medical Service, Fitzsimons Army Hospital, Denver, Colorado

J. Maxwell Chamberlain, M.D., Associate Professor of Surgery, Columbia University College of Physicians and Surgeons, New York City

Mr. William Steenken, Jr., The Trudeau Foundation for the Clinical and Experimental Study of Pulmonary Disease, Trudeau Laboratory, Trudeau, N. Y.

Oscar Auerbach, M.D., Chief, Laboratory Service, Veterans Administration Hospital, East Orange, N. J.

Smoker